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ABSTRACT

A model for habilitating mentally retarded adolescent offenders is described. Discussion of historical background indicates a lack of programs for this population. A data-based profile of the population covers range of developmental delay, adaptive behavior scores, social skill development, academic achievement, arrest history, racial composition, and incidence of emotional disturbance. The need for training the adolescents to re-enter the community is emphasized, and specific treatment objectives toward that end are enumerated for aspects of behavioral excesses, deficits, and family involvement. Adaptation of the original unsuccessful treatment program in a group home included environmental engineering to reflect a more controlled environment while maintaining a token economy/timeout approach. Behavior improvements are reviewed, and floor plans showing design features are provided. Additional features described include transition through the program, setting (institution vs. community), outcome indices (such as treatment duration, recidivism, rates of aggression and non-compliance), vocational orientation, therapy, recreation, and family involvement. Among appended information are descriptions of programs designed to reduce antisocial behavior and generalize adaptive behavior. (CL)

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COMMUNITY RESIDENTIAL TREATMENT OF MR ADOLESCENT OFFENDERS

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I. INTRODUCTION

Over the past decade, a growing number of mentally retarded (MR) adolescent offenders have been diverted from the criminal justice into the mental retardation system. For the most part, these are aggressive youth in the mild range of mental retardation who are functionally illiterate, and who have varying histories of criminal involvement and failure in treatment. While many of these young offenders are now committed to state institutions for the retarded, in some areas they are being court-ordered into community in-patient programs.

The problem which these events pose for local service providers is that technology specific to community-based treatment of this young offender population has not evolved appreciably. The approach most frequently mentioned in community residential treatment of delinquent youth, the Achievement Place model, does not seem well suited for adolescent MR offenders. This paradigm was designed primarily for youth who had not engaged in violent crimes, and who could adapt to public school.

Experience indicates that most adolescent MR offenders are highly aggressive, to a point where they cannot function adequately in a conventional educational setting at the onset of treatment. Moreover, our preliminary evidence indicates that this group's aggressive behavior does not decrease under a traditional "family teaching" treatment, that vandalism of the group home becomes extensive, and that runaway behavior becomes rampant.

The only treatment formulated specifically for adolescent MR offenders which has been reported in the literature up till now was operated at Murdock Center, North Carolina between 1965-71 (by John Burchard). In that approach, a token economy and time out techniques were combined to treat antisocial behavior. Unfortunately, the apparent effectiveness of that treatment was not corroborated empirically. Moreover, the Murdock model has not been duplicated and assessed within a community-based program.

In 1980, circumstances permitted an adaptation of that paradigm to a community-based residence for adolescent MR offenders, and allowed for some systematic evaluation of its efficacy in treating this emergent population. This workshop draws extensively upon the conceptual and practical information

generated by that program.

Our primary purpose today will be to overview what that experience and all our avialable information indicates as the most rational model for habilitating MR adolescent offenders. This model is a culmination of our 5 years of community residential programming with these young offenders, outcome data generated by application of the model, and relevant research from the field of mental retardation.

We will not examine in detail all aspects of this treatment paradigm. Instead, we will focus on basic concepts that must be understood to plan a viable community residential program for these youth. Due to the complexity of habilitating multiproblem clients, we do not intend to make you experts in program development for this group. However, with what you learn from us, you should be able to assess whether a proposed program for MR adolescent offenders is likely to succeed, and why.

If you will look at the handout, you will see the topics that will be covered and their sequence. Let's briefly go over topic list so I can familiarize you with the type of information to be presented in conjunction with each.

A. Historical Background. Here we'llexamine why seperate programs were established for these youth, apart from the conventional MR and juvenile justice population.

B. Population Characteristics. We will consider selected variables that tend to describe and convey the type of behavior to expect from these young offenders in residential treatment.

C. Treatment Goal. What appears to be the most reasonable goal that should be expected of a residential treatment program for this group will be presented and discussed.

D. Specific Treatment Objectives. Towards what concrete treatment objectshould the program be working to assure that its residents are actually being habilitated?

E. Discharge Criteria. How long should residents participate in the program -- how can we tell they are ready to move on?

F. Treatment. What happens when we provide this population with a conventional group home treatment? How can that approach be improved?

G. Treatment Setting. Features of the residence that hinder and facilitate consistent behavioral intervention must be identified.

H. Treatment Program Location. Based upon available information, what is the most logical location for a residential habilitation program for these youth? Should it be institutionally- or community-based or does it make any difference?

I. Client Movement Through the Program. From the data available, how should the program's structure be lossened as a youth's behavior improves? What are some criteria to indicate that he or she is ready to move into a less structured, less restrcitive living arrangement?

J. Outcome Data. How well does the treatment model which has been advocated eliminate/reduce this population's aggression? Is there any evidence that effects endure upon discharge? How aggressive can we expect new admissions to be, and for how long?

K. Summary. Rather than reviewing all the material that has been covered to that point, in this section we will identify and briefly discuss the entire array of habilitation services required by this population.

L. References. At this time, we will provide a Reference Handout, and we will briefly annotate that list for you to indicate where specific information can be located.

M. Appendeces. In this section we usually include material that we believe will be most useful to the group we are addressing. For this presentation, we have selected copies of behavior therapy programs that we use in our residential program. The first one is used with new admissions, it is highly structured, and intended to reduce aggression rapidly. The other, a less structured program, is used with those whose aggression has been reduced to a desired level. Its purpose is to assure that those gains generalize or endure. We will discuss both programs, in non-technical language for those of you who wish to do so.

Please feel free to ask questions as they occur to you, and during breaks in the presentation. We will be available afterwards for very specific questions, or you can write us at the address in the program.

II. HISTORICAL BACKGROUND

The first discrete habilitation programs specifically for mentally retarded offenders of any age emerged coincidentaly on the grounds of institutions for the mentally retarded. At some of these facilities, adolescents and young adult residents who engaged in high frequency or very intense violent and/or criminal behavior towards other clients would form small groups, much as they were accustomed to doing in their communities. These cliques frequently preyed upon the lower level and weaker residents, in the form of extortion, theft, and various forms of physical and sexual abuse. One method for eliminating this type of victimization was to segregate these aggressive, "criminal-like" residents into locked, self-contained residential units on the grounds of the institution.

The first of these MR offender program precursors was established at Murdock Center in Butner, North Carolina in 1965. That unit was designed and directed by John Burchard, who we might regard as the "father" of residential treatment of MR offenders. It was he who provided the first empirically-based programming guidelines for this population, which included the token economy and time-out procedures. When Dr. Burchard moved to the University of Vermont, the Intensive Training Unit was disbanded (1971).

A similar intensive treatment program was founded on the grounds of the Johnstone Training and Research Center in Bordertown, New Jersey in 1966. It was named the Yepsen Unit, a name that it retains today. That Unit is still operating at the same site, and is the oldest MR offender program in existance in this country.

At both the North Carolina and New Jersey sites, adolescents and adults tended to be treated together. The primary grouping consideration seemed to be severity and chronicity of antisocial behavior rather than chronological age.

It appears that the first residential program designed specifically for adolescent MR offenders was established on the grounds of Camarillo State Hospital in Camarillo, California, between Los Angeles and San Diego. This was in 1975, and that program is still in operation today.

Show overhead of 50-State Survey. As you can see, subsequently several other states have founded institutionally-based programs for adolescent MR offenders. These are: Florida, Mississippi, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas, Washington, and Wyoming.

As you will also note from Table 1, very few cimmunity-based residential treatment programs have been developed to date for these young offenders. In fact, they exist only in Texas, Tennessee, and Wyoming. They were begun in late 1977. At that time, an 8-bed group home was established in Nashville, and a 15-bed residence in Fort Worth. Within a year, 3 10-bed group homes were opened in Houston.

According to our 1982 50-State Survey, there should now exist 310 institutionally-based residential beds for this population (280 on-line, and 30 more expected by end of 1983). 125 community-based residential beds should now be available. In terms of future developmental trends, top administrators in 35 states indicated a need for both types of programs for adolescent MR offenders. Unfortunately, according to their reports, in 23 of these states where there exist no institutionally-based programs, no legislative interest likewise exists to fund them. In terms of community-based programs, in 31 of those states none exist and there is no legislative committment to them. Based upon our projections, this year about 5,000 adolescent MR offenders will require some form of residential treatment, but there will be only about 435 avialable beds nationwide. And in 36 states, no residential programs specifically designed for this population will be avialable.

TABLE 1

EXISTING RESIDENTIAL PROGRAMS FOR MENTALLY RETARDED OFFENDERS BY STATE, SITE OF PROGRAM, CAPACITY, AND TIME IN OPERATION

State	Program Site		Capacity	Years in Operation[1]
	Adolescents	Adults		
California	Institution	Institution	120-150	1-7
Florida	Institution	Institution	30-50	2-4
Minnesota	None	Community	10	1
Mississippi	Institution	None	31	2-4
New Jersey	Institution	Institution	56	2-17
New York	Institution	Institution	48	2-4
Oregon	Institution	Institution	75-100	2-4
Pennsylvania	Institution	None	20	3
		Community	20	2
South Carolina	None	Institution	32	3
Tennessee	Institution	Institution	30-50	2-4
	Community	Community	70[2]	2-4
Texas	Community	None	65	1-4
Virginia	Institution	Institution	75-100	2
Washington	None	Institution	75-100	1-3
		Community	20	1
Wisconsin	None	Institution	30-50	1
Wyoming	Institution	Institution	30-50	2-4
	Community	Community	30-50	2-4

[1]Where more than one program exists, a range is reported.

[2]One 10-bed adult program; all others are adolescent programs.

III. POPULATION CHARACTERISTICS

Of central concern to those who plan treatment programs is the issue of common client characteristics. To plan a rational program, one must know what to expect of the clientele. Generally, the more we know about them, particularily in residential programs, the better we can anticipate and avoid future problems through program and physical plant design.

To our knowledge, no empirically-based characteristics have been established for this population. Descriptions that do exist tend to derive from casual observation, anecdote, and extrapolations of what is known of the general mentally retarded population. How representative of adolescent MR offenders these are therefore remains speculative.

To bridge this gap in knowledge somewhat, we have compiled a data-based profile of adolescent MR offenders that incorporates characteristics which appear central to working with them effectively. This profile represents a composite of the 59 youth who have entered a residential program for this population at the Fort Worth State School during the past 2½ years.

Age (M=15-4). Although children as young as 11 have been placed into the program, the courts generally do not opt for residential palcement at that age. They are inclinded to give the family more opportunities to manage the child's behavior. If the family is successful, everyone benefits. But, if they're not, then you receive a child who has about 4 years of highly potent intermittent reinforcement for antisocial behavior.

IQ (M=53). While our sample indicated an average assessed intellectual functioning within the low mild range of developmental delay, it was somewhat

TABLE 2

SELECTED CHARACTERISTICS OF ADOLESCENT MR OFFENDERS[a]

Mean Age[b]	Mean IQ[c]	Mean Academic Achievement Levels[d]			Sex Composition	Racial Composition	Number Emotionally Disturbed[e]
		Reading	Spelling	Arithmetic			
15.4	53	2.1	2.0	2.4	8 Female 51 Male	5 Hispanic 7 Caucasian 47 Black	11

[a] n=59

[b] Range=11-1 to 18-6, Md=15-7

[c] Range=36 to 66, Md=55 (Measured with WISC-R, Stanford-Binet, and WAIS [4])

[d] Reading Range=0.7 to 4.6, Md=1.8; Spelling Range=0.6 to 3.6, Md=1.9; Arithmetic Range=0.5 to 4.4, Md=2.3 (Measured with WRAT, Keymath Test, and Woodcock Reading Tests; Reported in Grade Equivalents)

[e] Schizophrenia=3; Schizoid Disorder=2; Borderline Personality=4; Intermittent Explosive Disorder=2 (In this sample, another 28 were diagnosed as Conduct Disorder, Undersocialized, Aggressive)

skewed towards the high end of the mild range. No empirical item analysis was conducted to disclose specific functional deficits. However, we noted that no consistent verbal/performance dichotomy seemed to exist on the Wechsler Scales. It seemed though that test items which were academically-grounded or which necessitated adequate verbal receptive, processing, and/or expressive skills were performed with most difficulty (based on clinical observations). It was noted generally that test performance was hampered by educational, psycholiguistic, and perceptual-motor deficits.

Based upon observation, it seems that youth within the moderate range of developmental delay (IQ of 36-51) do not evidence what one would consider "criminal" behavior. They tend to be aggressive when their wants are thwarted, they will steal, and they will run away from the group home to avoid structure and consequences. However, their behavior does not appear to be premeditated--they usually do not plan to attack someone, to steal a particular item in a certain way, or to run away on a permanent basis. Their behavior seems much more spontaneous, their anger is more transitory, and they are less grudge-bearing. It may be that that their lower cognitive functioning precludes longer term planning. Be that as it may, we have also noted that youth with IQs in the high mild range respond differently to our program than do their lower functioning counter-parts: their aggression will seem to be eliminated within 6-8 weeks in treatment, only to relapse several times thereafter. They tend to try to manipulate aspects of the program rather than abide by its structure. Lower functioning youth attack the program's structure frontally. Their aggression takes longer to eliminate, but there tend to be few relapses. Interestingly, the total time required by both groups to eliminate aggression consistently turns out to be about the same (all other variables being equal).

Adaptive Behavior (AAMD ABS, Md=81; Vineland, M=64 or 9-6). Of our sample, 38 had adaptive behavior assessed with the AAMD ABS, while 21 had been evaluated with the Vineland Scale of Social Maturity. Accordingly, we were able to compare them not only to MR adolescents in general, but to non-retarded adolescents.

The distribution of ABS scores was extremely skewed towards the 10th decile, which indicated that the Md was the most appropriate central tendency measure for that data. Their 8.1 decile functioning indicates that only 19% of the conventional institutionalized mentally retarded population is more adept at basic living skills. Since these youth function more proficiently that the average mentally retarded person, they do have the capacity to victimize the general institutional clientele.

Compared to non-retarded youth, this sample's adaptive behavior averaged to the 64th percentile. This sub-standard adeptness probably helps to account for these youth being easily victimized by their non-retarded counterparts.

Compared with the typical MR population, our sample was better developed physically. This finding indicates that they should be highly mobile, agile, and strong youth. All these indications have been amply verified by our staff. This group was also well versed in basic domestic activities, such as housekeeping and simple food preparation. This means that programmatic emphasis must be on prompting and motivating the performance of those living skills -- not their step-wise teaching. For example, it will not be necessary to write a step-by-step bedmaking curriculum. It will be necessary to design a prompting/motivational system to assure that beds get made.

The greatest adaptive deficiencies were noted in 3 areas:

1. Independent functioning (cleanliness/personal hygiene, clothing

TABLE 3

ADAPTIVE BEHAVIOR OF MR ADOLESCENT OFFENDERS[a]

Adaptive Behavior	Mean Decile Score	Median Decile Score	Decile Score Range
Independent Functioning	68	57	40 - 77
Physical Development	83	98	20 - 100
Economic Activity	75	79	47 - 100
Language Development	70	70	25 - 100
Numbers & Time	72	73	30 - 100
Domestic Activity	84	89	21 - 100
Vocational Activity	67	63	20 - 100
Self-Direction	53	58	5 - 93
Responsibility	77	80	38 - 100
Socialization	74	82	20 - 100
TOTAL	72	81	N/A

[a]Measured with the AAMD ABS (n = 38)

Sample Characteristics: IQ Range = 40 - 66, M = 55, Md = 54
Age Range = 13-7 to 18-6, M = 15-5, Md = 15-8

ADAPTIVE BEHAVIOR OF MR ADOLESCENT OFFENDERS[a]

Measure	Mean	Median	Range
Social Quotient	64	64	46 to 82
Social Age	9-8	9-8	7-6 to 10-10

[a]Measured with the Vineland Social Maturity Scale (n = 21)

Sample Characteristics: IQ Range = 36 to 65, M = 55, Md = 57
Age Range = 11-1 to 16-10, M = 14.7, Md = 15-1

care, use of public transportation, telephoning skills, etc.)

2. Self-direction (poor attention to task, low perseverence, low motivation for self-initiating tasks/activities, high suggestibility)
3. Vocational orientation (lack of simple tool/household equipment knowledge, careless performance, poor work habits, intolerance of negative feedback, etc.)

The implication of those deficits is that step-by-step instruction in these 3 areas must be provided to virtually all members of this population.

Social Skills. Another dimension of adaptive behavior that is receiving increasing professional attention is social skill. Social skill can be defined broadly as the ability to use socially-acceptable methods to motivate others to do what we wish them to do. And, at times, to motivate them not to do what they are intending. Virtually all client populations evidence considerable social skill deficiencies. Over the past decade, the practice of teaching social skills directly has grown into an adjunct for many treatment programs.

The evaluation instrument we used to guage this dimension is the pre-test of the ASSET Social Skill Program for Adolescents. This training package is intended for the general adolescent population, so it contrasted our sample with what the ASSET developers considered to be average youth. The group that we evaluated with the ASSET pre-test had progressed to the highest level in our program. We therefore contrasted our best clients, so to speak, with a hypothetical adequately functioning adolescent. Our sample was small, so generalization should be cautious.

The assessment consisted of pre-specified interpersonal situations which the subjects role-played (privately) with the evaluator. To perform each scene

TABLE 4

BASIC SOCIAL SKILL COMPETENCY OF ADOLESCENT MR OFFENDERS[a]

Per Cent Competency Measure	Social Skill Catagory						
	Giving Positive Feedback (n=15)	Giving Negative Feedback (n=15)	Accept'g Negative Feedback (n=15)	Resist-ing Peer Pressure (n=14)	Following Instructions (n=13)	Negotiation (n=14)	Conversation (n=13)
Mean	38	26	34	31	52	58	57
Median	34	18	23	25	33	48	57
Range	17-83	0-56	15-62	10-55	16-92	39-68	26-97

[a]The pre-training procedures developed for use with the ASSET Social Skill Program for Adolescents (Hazel et al., 1981) was used to assess competency. Scores obtained with that procedure are in terms of per cent of tasks completed.

Sample Characteristics

Age Range = 13-11 to 19-3, M=16-6, Md=16-4.

IQ Range = 41 to 64, M=54, Md=53.

Adaptive Behavior Range (AAMD ABS) = 65 to 97, M=81, Md=81.

Number of Arrests Range = 2 to 15, M=6, Md=4.

Sex Composition of Sample = 3 females, 12 males.

correctly, the subject had to utilize certain facilitating behaviors. The percent of those behaviors that were used in the role-play became the score for that skill. For example, let's say that giving positive feedback requires making eye contact, smiling, staying on the subject, and 5 other behaviors. A subject demonstrating 4 of those would score 50% on "Giving Negative Feedback". It can also be interpreted to mean that he uses that skill about ½ as effectively as non-retarded adolescents.

It seems apparent from the first 4 scores that our sample lacks assertive behavior. By that I don't mean that they're not aggressive. I mean that they do not give and receive negative feedback in a non-aggressive manner. Neither do they seem adept at resisting peer provocation -- again, they tend to respond aggressively. And finally, they do not seem to use positive feedback or compliments to advantage.

The "Following Instructions" and "Negotiation" skill scores are too difficult to interpret since the sample's scores were extensively skewed towards the lower end of the scale. The means seemed to overstate these competencies. Clinical observation suggests that this population performs neither task with much success.

It is interesting to note that the best developed social competency was found to exist in the area of "Conversation". This finding corroborates the recurrent experience of casual observers that this population seems to be functioning much higher than indicated by standarized tests since its conversational skills are apparently so well developed. Closer examination reveals that the content of their conversation tends to revolve around several basic demands, denials, request, self-aggrandizements, etc., which renders it of a much poorer quality than evident at first glance. In many cases, it appears that their conversations

serve a "process" purpose (contact with others) rather than a content function (communication). Communication peculiarities such as these, as well as rather small volcabularies tend to limit this population's conversational skill.

Based upon these data and our clinical assessments, it seems that social skill training must be considered as an adjunct to any treatment program that seeks to eliminate maladaptive/antisocial behavior. It should be used to systematically teach prosocial alternative behavior.

Academic Achievement (Reading 2.1, Spelling 2.0, Math 2.4). Most of this sample tends to function academically at the beginning 2nd grade level. There was an occasssional youth who could read adequately or performa math computations at the 3rd or 4th grade level. However, there was never a case where basic academic performance did not fall at least 5 grades below what would be expected on the basis of chronological age alone.

In terms of reading ability, word attack skills tend to be very poor or nonexistant -- in many cases, reading is actually guessing.Comprehension seems somewhat better, as long as sentences are brief and concrete. "Where are your blue tennis shoes?" Not, "Find something constructive to do."

Math skills tend to be only minimally more developed than reading competency. Many youth are able to perform simple addition and subtraction, but are unable to carry -- they use fingers for that purpose. Multiplication and division seem alien to this population. In general, they can use money for simple purchases, but will be unable to determine if their change is correct.

Those findings clearly indicate that these youth require considerable academic training before they will be able to perform the basic reading/writing/math tasks that prevade modern life. Functional remedial academic education must be

a central component of any habilitation program for them. Our experience indicates that many of these youth tend to be embarassed by their poor academic skills, and will resist formal academic instruction, at least in the initial phase of treatment.

Number and Reasons for Arrest (Total=425, M=8 [n=8]). Recorded number of arrests varied considerably across our sample, from 1 to 22. Given that about ½ of all arrested youth are released without booking, which means that those arrests typically are not permanently recorded, those numbers propably significantly understate the actual number of arrests. Moreover, since only about 17% of all crimes are solved, number of arrests probably significantly understates the actual criminal acts committed by most members of our sample.

We found that 28 or 47% were arrested most frequently on theft charges. In 66% of the sample, theft was among the top 3 charges on which this group was arrested most frequently.

Burglarly, which is essentially a theft-facilitating activity, accounted for the most frequent arrest charge in 13 youth or 22% of the sample. In 42% of this group, burglary was among the top three charges that precipiated arrest. Only 8 youth had no recorded arrests for burglary or theft.

The third most recurring criminal charge was for assault. While it accounted for the most frequent arrest reason in only 6 cases, in 13 others it was either the second or third most frequent cause. In 32% of the sample, assault was among the 3 top reasons for arrest.

These data tend to support clinical experience that this population will readily steal in cases when the opportunity presents itself, and often breaks into secured areas to facilitate theft. Residential programs for these

TABLE 5

MOST COMMON CRIMES OF ADOLESCENT MR OFFENDERS[a]

Type of Crime[b]	No. in Sample with Most Arrests for Crime	No. in Sample with Second Most Arrests for Crime	No. in Sample with Third Most Arrests for Crime
Theft	28	10	1
Burglary	13	11	1
Assault	6	8	5
Intoxication (Alcohol/Drugs)	3	3	3
Auto Theft	1	5	3
Runaway	4	3	1
Truancy	2	1	5
Indecency with a Child	2	3	0
Vandalism	0	3	0
Aggrevated Robbery	0	2	1
Prostitution	0	1	0

[a] n = 59

Age Range: 11-1 to 18-6, M = 15-4, Md = 15-7
IQ Range: 36 to 66, M = 53, Md = 55
Sex: 11% Female, 89% Male
Race: 8% Hispanic, 12% Caucasian, 80% Black

[b] Total number of arrests for the sample was 451
Range: 1-22, M=8, Md=6

youth must therefore take special precautions to secure property belonging to the program and residents.

Aggression (51 or 89%). The great majority of youth in this sample had reports of physical aggression towards peers, teachers, police officers, and/or parents in their records. In 18 cases (30%), parents reported being unable to control the child's behavior, and that efforts to do so prompted intense physical acting-out. 33 youth (56%) had failed in previous treatment and/or public school placements due to physical aggression.

The nature of our data did not permit identification of conditions that evoked physical aggression most frequently. However, as might be anticipated, our clinical observations indicate that it erupts most commonly when a desired item, activity, or privilege must be forfeited, and when compliance is forced with undesired requests, activities, or consequences.

Our experience indicates that most youth will not attack staff, even when they impose restrictions. Rather, they tend to displace their aggression upon one another. Especially during the initial phase of treatment, the predominant means of venting frustration, regarless of who induced it, seems to be attacking a weaker resident, or in the absence of such a suitable target, vandalism. Overall, these findings indicate that a residential program for this population must be prepared to manage and eliminate pervasive physical aggression.

Sex Composition (Female=8 or 14%, Male=51 or 86%). No empirical evidence exists to account for the great over-representations of males in our sample. We speculate that it results primarily from different cultural roles for females in our society, and judges' general disinclination to place girls into residential programs.

Unless a program for this young offender population can exclude females, special living arrangements must be made for them. It should be expected that consenting sexual activity will occur even with adequate staff. Our experience indicates no rapes of female clients. However, we do note verbal aggression among male clients over the real and imagined access to female clients' sexual favors. We were also forced to resolve the issue of contraception, which we did in favor of its use. Among our small sample of females, none has refused to take birth-control medication.

Racial Composition (8% Hispanic, 12% Caucasian, 80% Black). Again, our data did not lend itself to an analysis of factors that yielded the sample's racial composition. Clinical observation suggests that IQ testing artifacts probably accounted significantly. Among the most common, we suspect: narrow cultural orientation of the test, academically ladden test items, and minimal test performances by this population due to lack of motivation.

Emotional Disturbance (11 or 19%). For the most part, youth in our sample did not evidence behaviors peculiar enough to justify a diagnosis of emotional disturbance under DSM-III criteria. 28 members of this sample were diagnosed as "Conduct Disorder, Undersocialized, Aggressive" (312.00). Especially during the initial phase of treatment, their behavior frequently deteriorated into a rage reaction. These episodes were not always instigated by identifiable stressors, or the cause which incited them did not justify the magnitude of response. During such phsyical acting-out, little concern was shown for damage that might be inflicted upon others and property. Delusions, especially with paranoid content, were common during those times. However, according to accepted diagnostic criteria, these youth are not considered emotionally disturbed.

Of the 11 youth in our sample whose symptoms indicate emotional disturbance, 5 evidenced schiphrenic-type disorders: 3 youth presented symptoms of "Schizophrenia", 2 those of "Schizoid Disorder". Of the 4 youths diagnosed "Borderline Personality", all were prone to recurrent "Brief Reactive Psychosis" and some might be better classified as such.

The delusional and irrational behavior of these youth tends to be episodic, as is expected from these diagnoses. Their active psychoses is typically brought on by some identifiable stressor, and is dominated by intense agitation and sporadic violent acting-out. Delusional thought is pervasive, giving the impression that the youth is only loosely in contact with his objective environment. The duration of this irritated/delusional state is from several days to 2-3 months, in the absence of psychotropic intervention. Residual symptoms tend to persist longest in youth whose symptoms are those of "Schizophrenia". These include social isolation, daydreaming, depression, blunted affect, and vague speech.

Our observations suggest that duration of the residual phase is at least as long as the acute or psychotic phase. But eventually, these youth again become oriented and compliant. However, they always purvey a sense of "oddness". With our small sample, we find that the iterim between psychotic episodes increases with length in treatment.

In 2 other cases, an apparent epileptiod mechanism underlies periodic outburst of violent behavior. Typically, a burst of aggression follows prolonged periods of appropriate behavior, and precedes a series of grand mal seizures. During this aggressive state, these youth are extremely edgy, and over-react to behaviors and taunts of others that would normally be ignored. Delusional thought (paranoid, reference) is common during an acting-out episode, which gives the impression of loose contact with the actual environment. Remarkable physical strength can be marshalled during this time, and physical restraint is always required. The most appropriate DSM-III classification for this symptomology seems to be "Intermittent Explosive Disorder" (312.34), which is regarded as an impulse control disorder. (Only 6 in our sample were active epileptics.)

While only a small percentage of our sample qualified for a "dual diagnosis", the problems which they have caused for themselves, other clients, staff, and the program itself vastly exceeds those expected by their number alone. Due to their violent, adrenalin-fueled aggression, we were forced to make numerous modifications in the physical plant (escape-proof, indestructible), staffing (high ratio of large males), and treatment (psychiatric consultation, psychotropic medication, physical restraint procedures).

Based upon our experience, it seems that this is the most difficult sub-group to program, even more so that highly antisocial youth. Thus, it appears if a residential program can manage this group responsibly,

it will be able to accomodate any MR youth referred to it.

Adolescent MR Offender Composite. Based on our data and clinical experience, the following average, hypothetical youth emerges:

1. A 15½-year old black male, functioning in the low mild range of developmental delay (perhaps a 53-55 IQ). Physical development will be normal, no sensory impairment would be evident, and he would have no history of epilepsy.
2. Basic domestic and household tasks could be performed at entry level. However, personal hygiene, self-care, and various independent living skills (such as, effective use of public transportation, using newspaper want ads) would be absent or require considerable guidance. Attention to taks, perseverence, work quality would be poor in most performance areas.
3. Conversational skills are adequate to communicate needs and wants effectively. However, social skills in general will be paucid. Interactional style will be dominated by aggression, intimidation, and manipulation. Overall social maturity will be that of about a 9½-year old child.
4. Academic skills will be rudimentary, probably at beginning second grade level. Resistance to formal instruction will be demonstrated initially to disguise these deficits.
5. Arrests will have been primarily for theft-related charges. While recorded number of arrests will be about 8, more unrecorded arrests occurred. Moreover, the total number of significant criminal acts commited by the youth will number in the 20's.

So, does this mean that a residential program for this young offender population should maintain them in treatment until all their excesses and deficits are remediated? That might make sense if that program were the only habiliation provider within the community. But this is not the case. Every community has established a network of educational, vocational, and support services for its mentally retarded persons. Why should these youth be permanently excluded from such traditional, and less restrictive habilitation? Or, conversely, why should traditional MR service providers not share the responsibility for habilitating these youth?

The answer is -- they must. To maintain these clients in residence beyond a point where they can successfully participate in off-site habilitation violates their right to least restrictive treatment. Simultaneously, it constitutes a costly duplication of services.

Youth enter a residential program because, at that point in time, they can not be served in a more conventional manner -- aspects of their behavior exceed the resources of traditional service providers. The residential program is the only site, at least theoretically, that can deal with their magnitude of excesses. Implicit in this logic is that youth should be discharged from a residential program when they can successfully participate in traditional habilitation -- in most cases, that will be a special education program, an alternate day program, a sheltered workshop, or sheltered employment.

Therefore, it seems that the appropriate goal of residential programs for MR adolescent offenders should be: to train youth for re-entry into the conventional habilitation network which the community has established for its mentally retarded citizens.

6. While behavior may at times evidence considerable delusional thought, especially during agressive acting-out episodes, insufficient symptomology will exist for a diagnosis of emotional disturbance. Most likely, that maladaptive pattern will be diangosed as a conduct disorder resulting from undersocialization.

IV. TREATMENT GOAL

Unlike the adult correction system, where it hasn't yet been decided whether the goal is punishment or rehabilitation, that issue is well-settled in juvenile justice -- the goal is definitely rehabilitation, or in the case of MR youth, habilitation. So, does this mean that the goal of residential programs for MR adolescent offenders should be total habilitation? I don't think so. It seems that the appropriate goal of these in-patient programs should be: to begin the long and complex habilitation of this multiproblem population.

Offender habilitation is a lengthy and complicated process since there is no direct treatment of specific criminal behaviors which has proven effective with the general population. Most likely, the ineffectiveness of direct treatment lies in the multiple causation of criminal acts. For example, burglary seems to be variously motivated by an interaction of economic need, peer pressure, emotional state, liklihood of discovery, etc. A direct treatment of burglary must somehow permanently alter these highly variable factorsin such a manner that they would never interact again to elicit that behavior. It is highly unlikely that such a treatment will ever be formulated.

Given then that most criminal acts cannot be treated directly, offender programs instead strive to attack the "correlates" of criminal behavior. In that process, they work to reduce those behavioral excesses and deficits which seem to predispose members of their client population to a volunerability to commit crimes in general. Thus, for example, in our residential MR adolescent offender program, we work to eliminate socially maladaptive behaviors--physical/verbal aggression, theft, lying, sexual acting out,etc. -- and to strengthen socially appropriate behaviors--self-care, social skills, functional academics, etc.

V. SPECIFIC TREATMENT OBJECTIVES

Before this population can re-enter the community and successfully participate in generic habilitation services, the following changes must be achieved.

I. Behavioral Excesses must be eliminated and/or reduced.

A. Physical aggression, runaway, sexual acting-out, theft, and vandalism must be eliminated. Evidence that they no longer exist is their non-occurrence in the treatment setting for a pre-specified period. To permit a youth to leave the program while such behaviors are still active will lead to his almost certain expulsion from conventional habilitation sites, and further residential placement. A program for these adolescents must therefore incorporate effective strategies for eliminating those problem behaviors.

B. Verbal aggression and non-compliance must be reduced to a tolerable level -- one which is typical of adolescents, who normally tend to be somewhat rebellious. It is unrealistic to attempt to make these youth more "normal" than their non-offender, non-retarded peers. The residential program must therefore also incorporate interventions for reducing these disruptive behaviors, and establish tolerance criteria.

C. Major psychiatric symptoms (delusions, hallucinations, loose associations, self-abuse, etc.) must be eliminated, or controlled through medication. These will preclude active participation in habilitation, and, in many cases, exclusion from those programs. The residential program must therefore be capable of psychiatric intervention.

II. Behavioral deficits must be reduced.

A. Independent living skills, social skills, and functional academic skills must be taught and strengthened. Conventional community MR service providers can train these youth in those skills, so it is unnecessary for the residential program to set a goal of training clients to their highest ability level in these areas. But, it should teach them to exercise adequate hygiene, clothing care, and basic social skills to facilitate their acceptance into the conventional habilitation network. Similarily, the possession of functional academic skills will permit these youth to participate more fully in any habilitation endeavor. A residential program must therefore provide living, social, and academic skills training to its clients.

B. A concrete vocational oreintation should be provided. Due to their developmental delay, most of these youth have no idea that they must be employed in the future to access those items, activities, and privileges which have always been dispensed to them by adults. Relatedly, they have no realistic knowledge of the rules of the work setting -- being on time, persevering with a task, maintaining work quality, accepting negative feedback from supervisors, etc. Inability to operationalize those concepts will exclude them from employment in the future, and thus invite criminal re-involvement. Accordingly, the program must provide these clients with a rudimentary knowledge of work-world rules. Since this population is unable to learn such complex concepts verbally, the program must have access to a simulated work setting in which these can be concretly

presented.

III. Family involvement is essential if changes induced during treatment are to endure.

A. Regardless of how much parents reject, neglect, or abuse their children, a strong parent-child bond remains. Practically speaking, this means that the parent can exert considerable influence over the child's behavior during residential treatment, and especially after discharge. It is probably for that reason that those programs for delinquent youth who have involved the family have been most successful. Accordingly, a residential program for young MR offenders must actively strive to assure that the family's influence upon the child during residence is as positive as possible. Moreover, it must work to link the family with indicated social and MH support to assure its positive influence upon the youth after discharge.

B. Youth whose family has abandoned him/her must be linked with an advocate, big brother, etc. who can at least fill a surrogate parent role. Otherwise, there tends to be little motivation for behavior change, since the child comes to feel that "no one cares about me" so why try to change? It is difficult to find effective surrogates; thus, the program must maintain ongoing contact with agencies that recruit such volunteers, and attempt to match one with a youth as soon as possible after admission.

VI. DISCHARGE CRITERIA

Since the goal of a residential program is to prepare youth for re-entry into the conventional habilitation mainstream, it must, logically, discharge them when they are ready to function in that setting. How then do we know that they can do so?

There are probably numerous methods for projecting from current behavior the liklihood of success and failure in the non-treatment setting. But, the best indicator is always how well the youth does during a trial run. It thus would seem that the most convincing indicator would be an actual demonstration of responsible functioning in a non-treatment or nearly normal setting.

To determine if youth are ready for responsible participation in off-site habilitation, they should be enrolled in one once the behavioral excesses cited previously have been remediated.

Since youth are slated to leave the residential program once they have re-entered the conventional habilitation network, they must also demonstrate a readiness to live in a more normal living environment than the one in which the behavioral excesses have been rectified. For that demonstration, the program must have available a living setting which is less artificial or "near-normal".

After youth have demonstrated that they can participate responsbily in both a conventional habilitation setting and a minimally structured living environment, they are ready for discharge. Of course, discharge must be contingent upon availability of an appropriate site.

TABLE 6

SUMMARY OF TREATMENT OBJECTIVES AND DISCHARGE CRITERIA

TREATMENT OBJECTIVES

I. Reduce Behavioral Excesses

   A. Eliminate physical aggression, theft, vandalism, and runaway within the group home setting

   B. Reduce verbal aggression and non-compliance to within age-apprpriate levels within the group home setting

   C. Eliminate or control major symptoms of emotional disturbance

II. Reduce Behavioral Deficits

   A. Teach and strengthen independent living, social, and functional academic skills

   B. Provide a concrete (hands-on) vocational orientation

III. Involve the Family

   A. Elicit general family support of the treatment program, and specific cooperation on selected interventions

   B. Link the family with indicated mental health and social services

   C. Provide youth without parents a responsible surrogate

DISCHARGE CRITERIA

I. Demonstrated successful participation in an off-site habilitation program (public school, in most cases)

II. Demonstrated responsible living in a minimally structured home environment

III. Availability of a suitable placement setting (family, relative or foster home, conventional ICF-MR/DD group home)

VII. TREATMENT

All right, now that we know the important characteristics of our client population, have established the goal of treatment, and decided upon exit criteria, we're ready to design the treatment. So we go to the literature, and look up "residential treatment of adolescent MR offenders" to learn exactly which interventions work with this population. Unfortunately, only a handful of articles can be found, and these are largely anecdotal accounts. Given that dead-end, one is likely to look for guidance to the "Achievement Place" model. As many of you know, this is a "teaching family" approach for typical juvenile delinquents which was developed at the University of Kansas in the late 1960's.

Confronted with a similar challenge, we attempted to adapt a "teaching family" approach to this population. This is what we did.

1. Acquired a suitably large building and equipped it as a self-sufficient living/training environment for 15 adolescents MR offenders, in accord with the beloved ICF-MR/DD standards.
2. Hired sufficient staff, at a 1:4 staff-client ratio, who had some experience working with youth, and provided them with orientation training typically given to staff who work with institutionalized MRs.
3. Installed a point-based token economy system, designed to award clients points for appropriate/desired behavior and subtract or "fine" points for inappropriate/undesired behavior. (Mechanics elaborated in Appendix)
4. Constructed a time-out room for use with clients who were being physically aggressive.
5. Hired a special education teacher to provide on-site academics to clients whose behavior exceeded the public school's resources, and had direct services staff teach living skills.

6. Hired a social worker to interface with clients families.
7. Secured ample operating funds to assure sufficient supplies and equipment. Then, we admitted 10 youth.

On the surface, it seems like we had designed a comprehensive program. How do you think it worked out? Descriptively, here is what happened, and why.

1. Verbal aggression increasingly escalated into physical aggression, and physical aggression was increasingly directed from from clients to staff. In a typical 90-day period, we recorded a total of 185 physical aggressions for a sample of 8 clients. Moreover, the intensity of aggression increased, but we have no empirical measure to support that observation. Why did this happen? Because there was no consistent consequence for physical aggression. Although the program was designed to consequnece physical aggression with placement into the time-out room, this proved nearly impossible to do. Clients who needed time-out simply ran from the building, being successful in most cases. Since the punishment for physical aggression was at best uncertain, an insufficient deterrent existed.
2. Verbal aggression with program requirements escalated. For the sample of 8, there were 562 such recorded incidents. Verbal aggressions increasingly incorporating threats of grave physical violence, including homicide. Why did this happen? Because the token economy could be easily circumvented. If youth acted-out pervasively, incurring numerous "fines" or point losses, they could readily leave the group home and acquire reinforcers that had to be forfeited in the group home (such as cigarettes, soft drinks, by begging or stealing). If they did not earn a weekend home visit, they would go home anyway, and so forth. In addition, they obtained alcohol, marijunana, and weapons in

the community which tended to exacerbate their aggressive behavior.

3. As is probably evident, runaways became rampant. Clients would leave almost at will, and would do so long enough to sneak to the convenience stores for beer, or for several day-long expeditions into the community. There were 143 runaways among our sample of 8 youth during this 90-day period.
4. Needless to say, habilitation or any other form of planned activity was almost impossible -- there were a total of 889 major disruptive incidents during this 3-month period.
5. As a consequence of this chaotic situation, staff experienced immense stress. To many, it seemed as if the clients had control of the program. There were few resignations however since almost all staff were state employees, and wanted to continue. But almost everyone thought that they has made a mistake in joining the program. Had the program continued much longer without a prospect of staff re-gaining control, resignations would have been inevitable.
6. Finally, the extensive number of runaways, which we were programmatically obligated to report to the local law enforcement agencies, provoked commentary from the local police chief. He in turn inspired the local news media to conduct an "evaluation" of the program. And sure enough, their conclusions provoked great interest at the highest levels of our central office administration.

Again, quite obviously, these terminal sypmtoms indicated that some changes in our treatment program were indicated. Based on the problems I've outlined, what would be the primary solution you would advocate?

VIII. TREATMENT SETTINGS

As was readily apparent, the group home had to be re-designed to support consistent application of our treatment. We obviously had to be able to lock or secure at least one section of the residence to render it "escape-proof". How do you make a conventionally-built frame house with enough windows and doors to qualify it as a swiss chesse analog "escape-proof"?

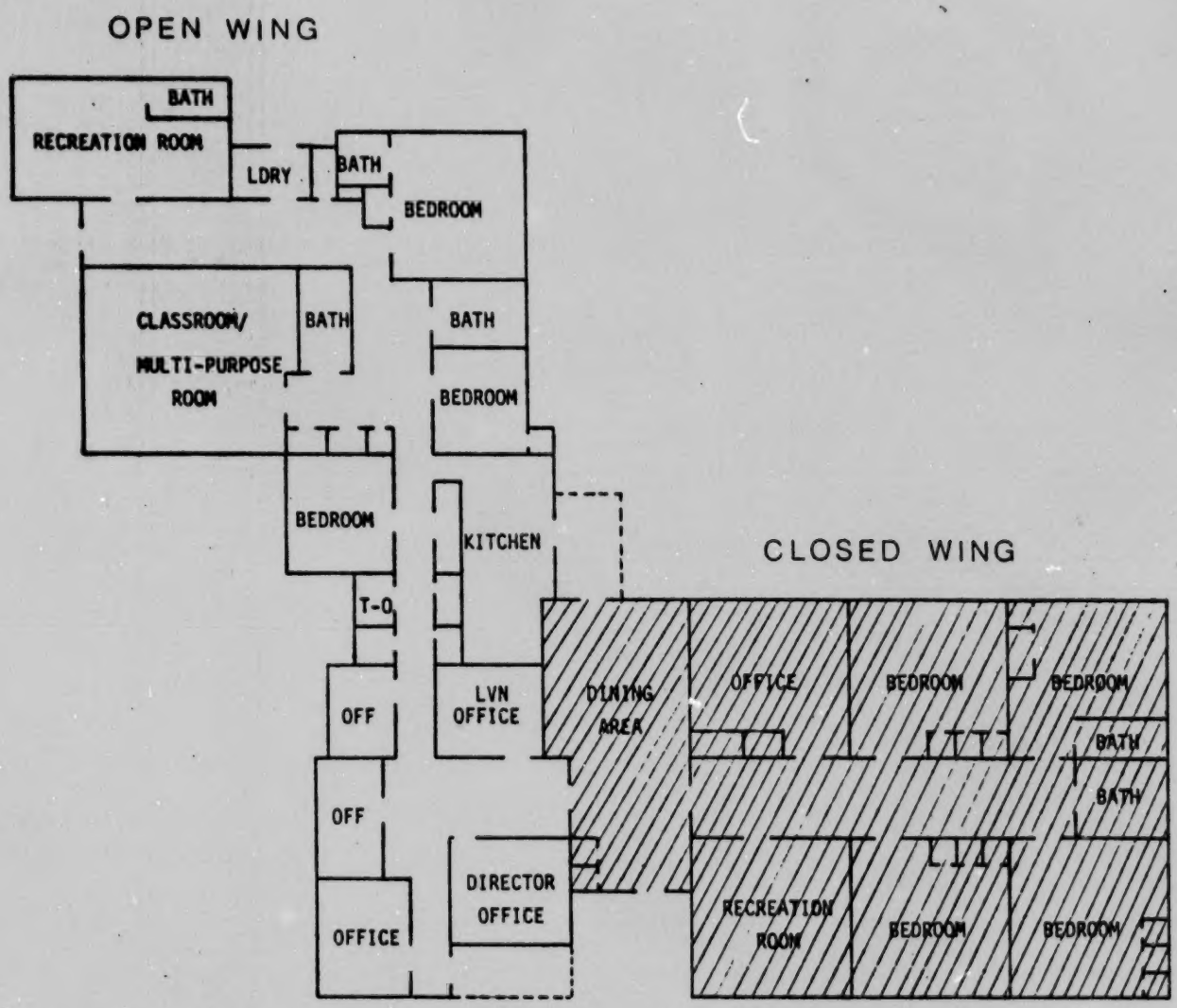
We took the most compact section of the building and modified its layout slightly into a completely self-contained living/training area: 4 bedrooms, 2 baths, 1 TV/reinforcement room, 1 office, 1 classroom. The following modifications were initiated in that section:

1. All walls and ceilings were panelled with 3/8" plywood, using bushels of long nails.
2. Solid oak doors were installed and fitted with dead bolts.
3. All windows were fitted with burglar bars, mounted within the room; steel mesh was welded to these and they were framed with 2"x4"s to prevent the passage of contraband.
4. All lights were recessed into the ceiling, and covered with ¼" clear vinyl sheeting.
5. All furniture and other item suitable as makeshift weapons was removed from the area (heavy modular furniture and cafeteria-style table/chair clusters were installed, and beds were bolted to the floor).

To protect clients who would live in that section, numerous fire safety precautions were instituted and stringently maintained.

Well, what impact did this environmental engineering have upon client behavior? To answer that question empirically, we compared the frequency of antisocial

FIGURE 1



The floorplan of the existing group home subsequent to its redesign into a controlled environment. Meals are served in two shifts so that one dining room suffices for the two resident groups. That room is also used as a classroom for residents being programmed in the closed wing.

behavior of the 8 youth who resided in the group home prior to its remodelling with a comperable sample, the first 8 youth who entered the group home upon its redesign. The comparison period was 90 days.

As I showed you earlier, in a 3-month period, the 8 adolescents in an open group home setting engaged in 185 physical aggressions, and 562 verbal aggressions. During the same time, there were 143 runaways. Its probably safe to assume that the incidence of aggression would have been even greater were youth not away from the group home so frequently on runaway episodes.

Once we began treating this population in a secure setting, those behaviors occurred at a much lower frequency. At that time, we used only a slightly different token economy/timeout approach, but the treatment setting was secure. The youth in this comparison sample were matched with the initial group (who was treated in the residence prior to remodelling) along major demographic dimensions. During their first 90 days in the program, they committed only 51 physical and 270 verbal aggressions. There were only 3 runaways, and they resulted only because of a structural defect in the building that allowed 3 youth to crash through a bedroom wall.

On the basis of this and ongoing data, we concluded that a secure setting is an indispensible adjunct to the initial treatment of young MR offenders. We believe it facilitates treatment by permitting staff to apply the token economy, and especially timeout procedures, consistently -- each time an aggressive act occurs. By experiencing that consequence inevitably, and observing its regular application to other residents, most youth discard their aggressive behavior within the first 3 to 5 months in treatment. Thereafter, the emphasis shifts from reduction to generalization training -- weaning the youth from the highly artificial living environment and its highly unusual consequences.

While this remodelled group home was functional in containing and managing aggression and runaway, it presented some problematic features:

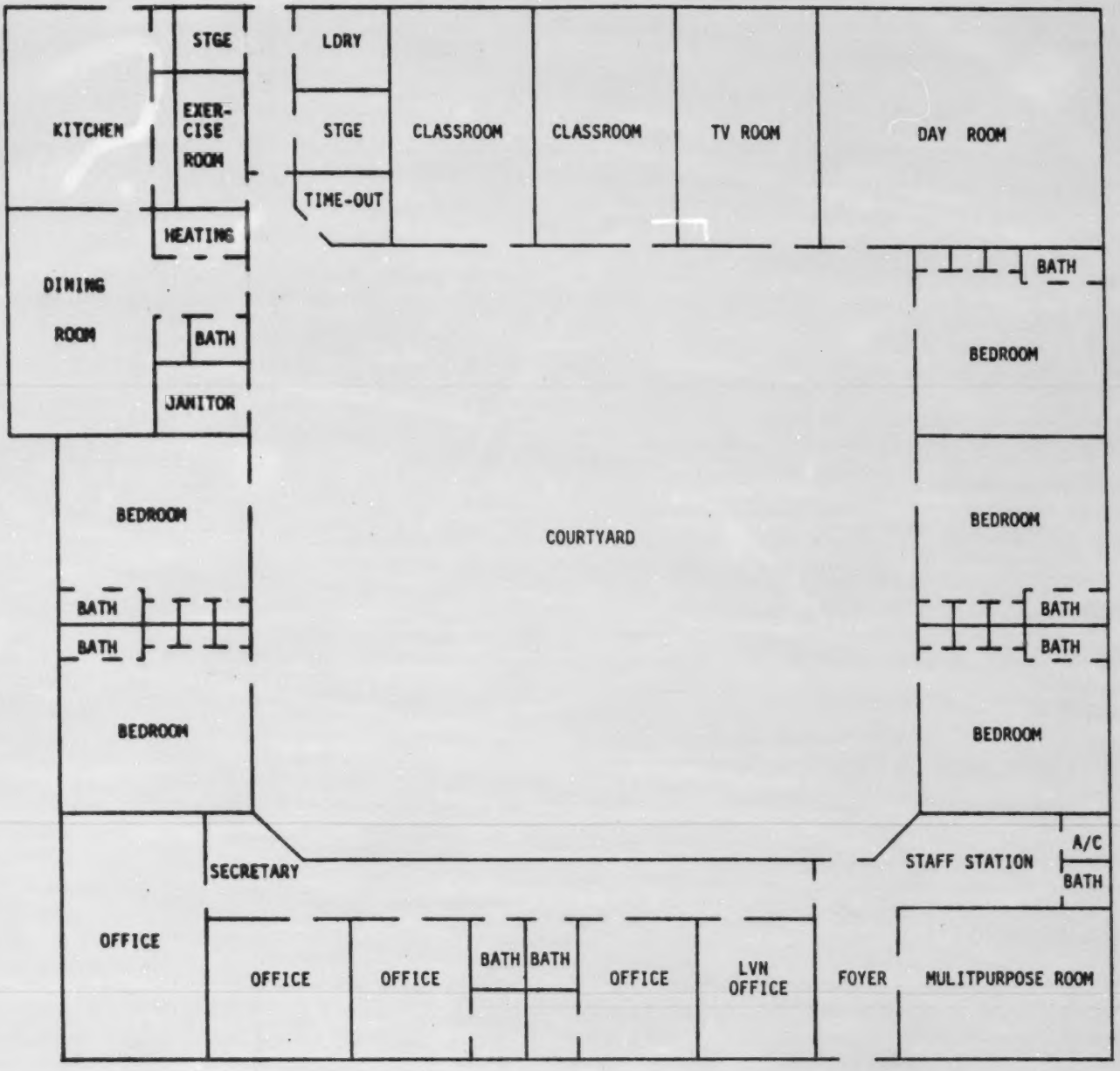
1. The wood construction of the building, its old electric wiring, the barred windows in the secure wing, and the one exit from that area seemed to pose a greater fire safety risk to youth living in the secure section than we were willing to assume.
2. There was insufficient room in the secure wing for physical types of recreation. Such activities were necessarily restrcited to calisthenics and the use of a small trampoline. But recreatioanl activities were essentially sedintary. As a result, residents could not work off excess energy or anxiety, which seemed highly indicated for some of them.
3. The secure wing was too small to accomodate 8 clients and 2-5 staff comfortably. It appeared that the resultant crowding and noise adversely affected some youth's behavior.

Had we added an outside recreational area (enclosed by a high fence), the physical exercise problems would have been resolved somewhat. And, it would have been possible to expand the size of the secure wing somewhat to eliminate crowding. However, due to the building's age and incomprehensible electrical wiring (which posed a fire hazard), we decided to construct a building tailored especially to our clientele and treatment.

The building I designed for that purpose incorporates the following concepts:

1. A compact client living/training area whose size can be reduced as needed to maintain high client visibility.
2. Escape-proof, indestructible, and virtually maintenance-free.
3. Secure, outside recreational area.
4. Maximum fire safety.

FIGURE 2



Floorplan for a group home desinged especially for initial treatment of chronically aggressive MR adolescent offenders.

The major structural features of this building are:

1. All walls, including partition walls, in the client areas are constructed of conrete blocks. Ceilings are of 5" concrete, and exterior windows (those facing the building's outside) are 6"x3'(high) 3/8" clear acrylic.
2. Doors in client areas are steel (solid wood for closets), fitted with dead bolt locks. All rooms in the client areas empty directly into the courtyard, and can be locked when not in use. All doors in that area swing into the courtyard so that they cannot be barricaded from the inside. (Courtyard is 53'x54')
3. There are 5 bedrooms, with bath -- 3 beds per room.
4. There is a fully equipped commercial kitchen.
5. There is a 6' awning, 12' from the ground, to protect clients and staff from inclement weather.

As I indicated previously in discussing Dicharge Criteria, a youth must demonstrate that he can live responsibly in a minimally structured home environment before he shoudl exit a residential program. Obviously, to do so that program must incorporate such a minimally structured or "near-normal" living setting. We have established such a group home for our graduates from the secure residences. Here are a few slides that will contrast this group home with the the ones we have just seen of the former.

As you will recall, the other Discharge Criteria calls for successful participation in off-site educational or vocational training. To facilitate our clients' transition from on-site to off-site habilitation, we have also established a small, traditional vocational education program off the grounds of the group homes. It is located in a business/industrial park to maximize its

importance and normalness to our residents. At this site, youth learn vocationally related academic skills (measuring with a ruler, reading basic job-site signs, filling out time cards). They are also taught employment-specific social skills (accepting supervisors' feedback, giving/requesting assistance from fellow employees, good work habits). And, they are introduced to basic tools. Essentially, youth are prepared for the vocational and/or vocationally oriented educational settings which they must eventually enter. These slides give some flavor of that program. (As you've noticed, none of the slides depict clients. This has been done to avoid sticky confidentiality and consent issues.)

IX. CLIENT MOVEMENT THROUGH THE PROGRAM

All youth are admitted into the Entry Unit, . which is secure. The first 30 days is an observation period during which we learn first-hand about the client, and formulate the ITP. On the basis of several variables we decide whether the client should remain in that residence until he is ready for the open group home of the program. If the youth's aggression is of very violent intensity, if he is large and older, and/or if he presents with significant emotional disturbance, he is typically transferred to the Intensive Unit. This program is designed to be very highly structured, long-term. It can accomodate any youth, regardless of severity of behavior.

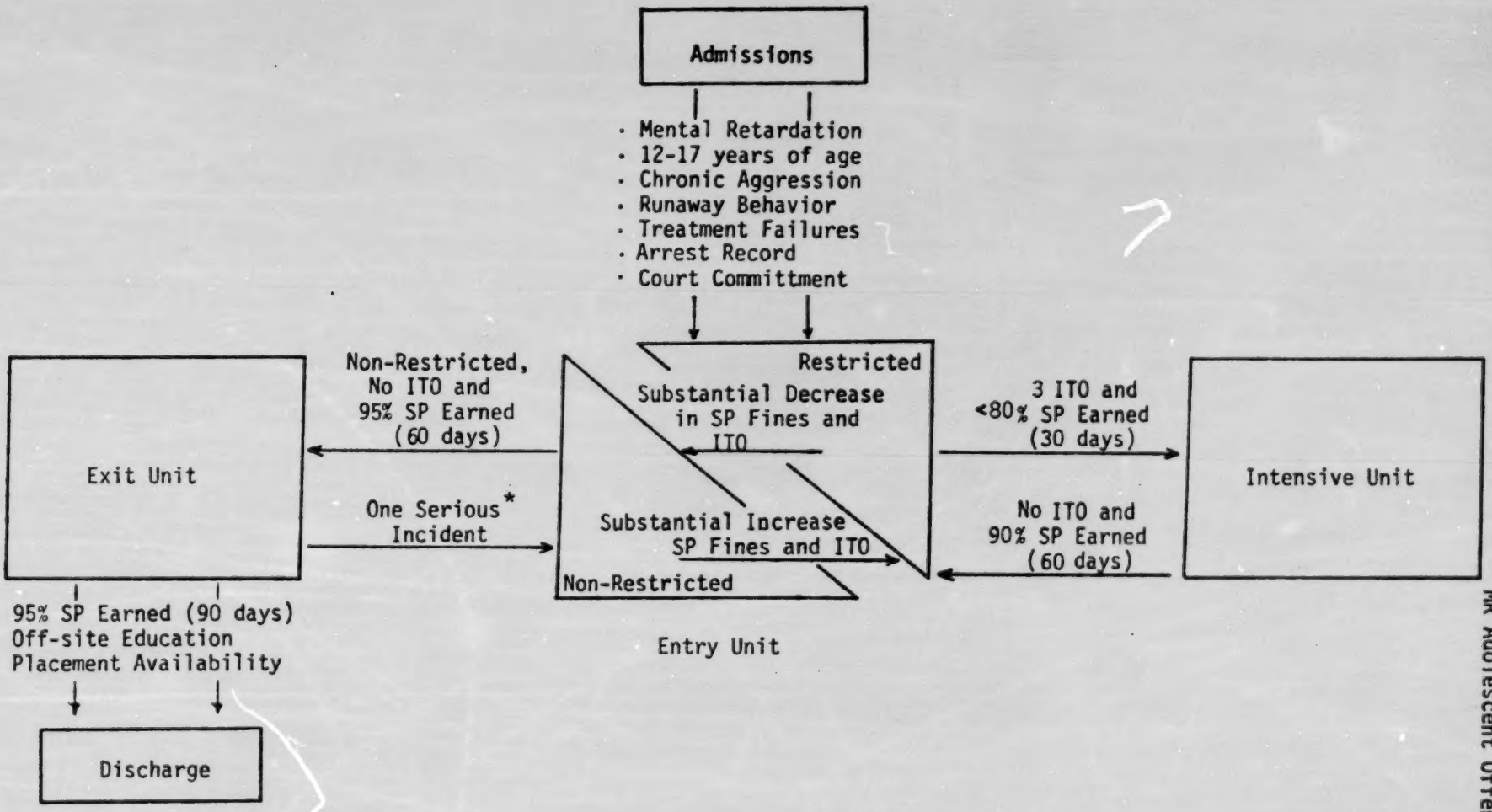
The minimum stay in either secure residence is 60 days, during which time pre-specified criteria must be met. Our experience indicates that clients rarely meet these within that time frame. However, we also find that with less stringent criteria backslides tend to occur and youth must be moved back.

All youth must meet they behavioral criteria before the can move to open (Exit) unit. It is not possible to move directly to that coventional group home from the Intensive Unit. Minimum stay at the open or Exit Unit is 90 days, at a pre-specified behavior level. Likewise, no client to date has demonstrated those criteria within that time frame.

Discharge from the Exit Unit is also contingent on successful participation in public school, or in the programs Vocational Education Unit. It is requires the availability of an appropriate setting, which is a problem for youth who have no responsible family or relatives. Clients who cannot function adequately at this open residence are moved back to one of the secure units.

FIGURE 3

CRITERIA WHICH TRIGGER AN INTERDISCIPLINARY TEAM MEETING TO CONSIDER THE NEED FOR CLIENT MOVEMENT BETWEEN PROGRAM COMPONENTS


Admissions
· Mental Retardation
· 12-17 years of age
· Chronic Aggression
· Runaway Behavior
· Treatment Failures
· Arrest Record
· Court Committment
Restricted
Substantial Decrease in SP Fines and ITO
Non-Restricted, No ITO and 95% SP Earned (60 days)
3 ITO and <80% SP Earned (30 days)
Exit Unit
Intensive Unit
One Serious* Incident
Substantial Increase SP Fines and ITO
No ITO and 90% SP Earned (60 days)
Non-Restricted
95% SP Earned (90 days) Off-site Education Placement Availability
Entry Unit
Discharge

Isolative Time Out Soical Points

*Serious episode of physical aggession, property destruction, or runaway (determined by the Interdisciplinary Team)

X. TREATMENT PROGRAM LOCATION

Our cumulative data indicate that these young offenders are avoidance specialists. Not only do they actively seek to avoid participation in many of the activities that constitute the treatment process, but they vigorously strive to avoid the programmed consequences of their irresponsible behavior. In short, they are highly prone to run away from the group home to elude what they don't like. Moreover, they are highly inclinded to run away to obtain what they are prevented from accessing in the group home--alcohol, marijuana, weapons, and items that belong to others. To be sure, there is the occassional young MR offender who will not leave the group home for those reasons, but the vast majority that have entered our program definitely require a secure environment for the initial phase of treatment. Certainly, a program that intends to accept all adolescent offenders must operate at least one secure unit.

Now, where should that secure residence be located, in the community or on the grounds of a youth corrections or mental retardation institution? According to the logic of some, since it's going to be a locked unit, it should be institutionally-based. After all, insitutions have much more experience with security matters since they contain the high-risk cases. That may be sound logic if one intends to place young MR offenders into a secure setting and keep them there for the entire duration of treatment.

But what if their treatment is only begun in a secure setting, and the second phase proceeds in an open group home. No problem, just transfer them to an open group home after they've "shaped up". Well, I'm sure you all know how tedious inter-agency transfers are. And, low and behold, sometimes (often) the referral is rejected for seemingly arbitrary reasons. To complicate the situation even more, what if the youth has to be moved back and forth several

times? Clearly, the secure and open residences must be operated by the same administration (at the program director level, if at all possible) to permit a smooth client movement when exit criteria have been met.

All right, then how about if we located both the secure and open group homes on the grounds of an institution. If you're interested only in the lowest possible short-term expenditure and ease of administration, that is probably the best option. But, if you're interested in the lowest possible long-term cost to society -- that is, if you're primarily interested in maximizing treatment effectiveness -- you must locate in the community.

At least 3 compelling reason necessitate community location:

1. The literature indicates that programs for delinquents that involve parents in various ways tend to be the most successful in decreasing recidivism. It is difficult to work effectively with parents strictly over the telephone. Face to face visit, especially within the family home appear to be very effective in establishing and maintaining genuine communication. Visits by the parents to the program help clarify for them its purposes and rationale, and seem to be very important in assuring the child that he has not been abandoned by them. Finally, weekend home visits are very powerful client motivators. When a young offender is removed from the community for treatment, parent contacts and visits become difficult, if not impossible. Similarily, weekend home visits become expensive for the child, and frequently involve long bus rides. Lastly, it is difficult to link parents effectively with indicated services across long distances, with agencies that are unfamiliar to the program's social worker.

2. As explained previously, residential programs for these young offenders cannot logically retain them until all their service needs are met. It seems most rational to discharge these youth into a less structured, more normal, or less restrictive setting once they have demonstrated that they can function in such an environment, and once they can participate responsibly in conventional educational programs.

   If the treatment program is located away from the youth's community, it will be necessary for him to enroll in an appropriate educational program within that community upon his return. That requirement presupposes that the youth and/or his family can decide which educational/vocational program is most indicated, and how to access it. It also ignores the stresss which the youth will experience as a new student in a strange setting. These factors could easily derail the youth's genuine intention to enter his community's educational network.

   Since according to this psychoeducational treatment model, on-going participation in the conventional habilitation network is crucial upon discharge from residential programming, it must be designed to maximize the probability that its graduates do so. Locating the program within the community will remove obvious obstacles to this necessary on-going habilitation by maintianing its continuity.

3. As part of independence training, the mentally retarded must learn how to utilize the various public support (social, medical, judicial, etc.) systems of the community. Doing so effectively could readily preclude criminal behavior in many situations. Since the nature of public services tends to vary between locales, and MRs have difficulty in generalizing,

it seems imperative to train these youth to access the public services specific to his community. This cannot be done if treatment is provided at a distant institutional site.

Because of these 3 important considerations, and lack of compelling arguements to the contrary, it seems most therapeutic to locate residential programs for adolescent MR offenders within the community. Since most youth placed in such programs seem to come from large metropolitan aeras, it appears that regional location of residential programs at these sites is most indicated.

XI. OUTCOME DATA

The simplest means to provide some information on how well our program is habilitating this population is to answer several questions which I'm most frequently asked.

What is the average duration of treatment?

As indicated previously, discharge from this program should not be construed as a sign that the youth has been "cured" of delinquency. It merely means that he is now ready to re-enter the conventional community habilitation system to continue learning/improving those skills that will enable him to access legally items, activities, and privileges he desires. The question then is really, how long does it take this treatment approach to prepare the hypothetical, average young MR offender for re-entry into the regular educational network?

That time frame tends to vary considerably. To date, we've only had 6 youth complete the entire program, which has been intact for only 24 months. Based on how long it took for them, and upon projections of how long current clients will remain in the program, we believe that the great majority will remain for 19-32 months. Based upon experience and projections, we expect that ½ that time will be spent in a secure residence. Youth who proceed through the program in less than 1½ years are expected to constitute about 10% of the population. Those with emotional disturbance who require treatment beyond 3 years are likewise expected to account for about 10% of the population. There are 4-5 clients with long-standing emotional disturbances (who have been in several institutional placements) who are expected to require 4-5 years of treatment.

What is the recidivism of youth that have completed the program?

Since only 6 youth have completed the program, little data exists along this dimension. It seems though that youth who are discharged into relatively

structured settings and continue the habilitation process succeeded upon discharge. Four have been discharged to their families, and attend school. In 6 months, they have not been arrested. One youth was discharged to a conventional group home, which provided little structure and less programming. He was returned to our program for aggression towards someone in the community. The sixth youth was discharged to a grandmother who was unable to set limits. In a short while, he was dismissed from a sheltered workshop for refusing to comply with supervisors' requests, and returned to our program. These preliminary experiences indicate to us that habilitation must definitely continue after discharge from the formal program, and that these youth still need extensive structure/supervision at that time. That finding implicates that discharge sites must be carefully selected and evaluated.

How oftent is it necessary to apply timeout with this population in a secure setting?

This tends to vary somewhat between clients, but seems to average only about 5-10 incidents for non-emotionally disturbed youth during the entire stay in treatment (range=0-15). Moreover, the vast majority of need for timeout intervention occurs during the first 20 weeks of treatment. With emotionally disturbed clients, the need for timeout interventions persists much longer. We have had youth where the need for timeout recurred cyclically, over a 30 month period. With the emotionally disturbed, you can expect 20-25 aggressive episodes that will require timeout during the first 20 weeks of treatment. However, double that number is feasible in specific cases. The number of cycles during which timeout must be reinstituted also varies considerably. Upsurges in aggression are common subsequent to reduction of psychotropic medication.

TABLE 7

PRELIMINARY WEIGHTED PREDICTORS OF TIME IN TREATMENT[a]

Variable	Low	Moderate	High
Family Detachment/Pathology	3	5	10
Frequency of Physical Aggression	2	3	4
Intensity of Physical Aggression	2	3	5
Runaway Tendency	3	6	9
Emotional Disturbance	3	6	12
Number of Previous Placements	3	5	8
Number of Arrests	3	4	9

[a]In months

Example: A youth with a supportive family (3);
low rate, high intensity physical aggression (2+5=7);
moderate runaway tendency (6);
minor emotional disturbance (3);
one previous placement (3),
and a low number of arrests (3),
can be expected to be in this program for 25 months.

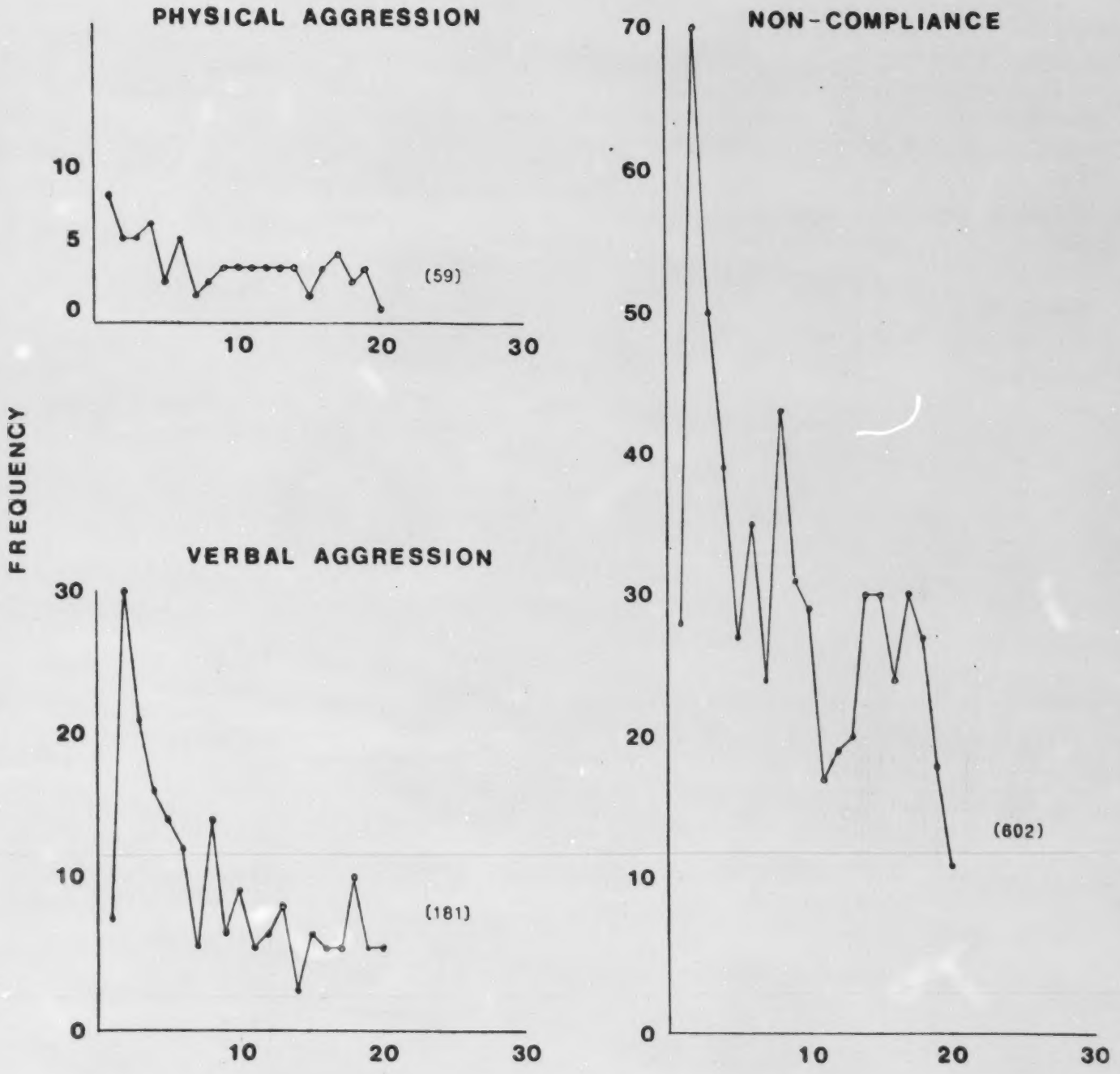
Interpretation: Low problem youth can be expected to be in this program for about 19 months.
Moderate problem clients will require about 32 months.
High problem clients will require about 57 months.

What rate of aggressive and non-compliant behavior should we expect from this population in residential treatment?

With most clients, physical aggression will dissipate increasingly as they experience that each incident will be consequenced with timeout. After about 8 weeks of treatment in a secure setting, physical aggression begins to taper off to a frequency of about 3 incidents for most youth (see Figure 4). By that time, if verbal aggression has also been treated with timeout, it will reduce to a frequency of 8 per week (all incidence figures are for a sample of 8 youth). Non-compliance, which is not consequenced with timeout, but only point fines, tends to hover at a higher rate, about 30 incidents per week. I should stress that this pattern is for the typical client. Emotionally disturbed or highly antisocial youth will not evidence such quick behavioral change in most cases.

If we look at the same maladaptive behaviors for a group of 8 MR adolescent offenders maintained in a conventional manner in a traditional group home, we note that aggression does not reduce after 8 weeks (see Figure 5). At the end of that time, physical aggression has escalated to about 20 incidents. Verbal aggression seems to have stabilized at an entry-level frequency of about 20 incidents per week. Non-compliance likewise has not increased above entry-level rate. However, you should notice the increasing number of runaways, which are occurring at about 12 per week at this point. Given the option of physically removing themselves from treatment, youth do not need to resist its structure through verbal aggression and non-compliance. Bear in mind also that during runaway episodes, those youths' maladaptive behaviors are not being observed, hence recorded. Thus the frequency of aggression and non-compliance for this group is understated.

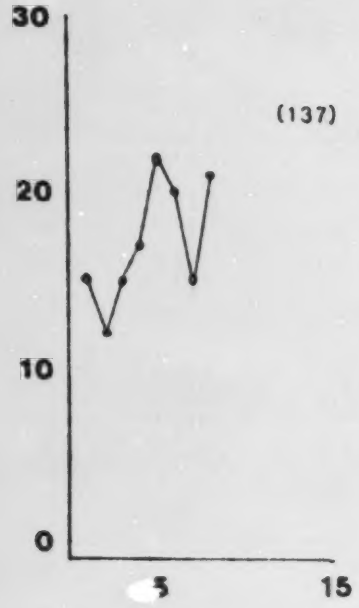
FIGURE 4


PHYSICAL AGGRESSION
10
5
0
10
20
30
(59)
NON-COMPLIANCE
70
60
50
40
30
20
10
0
10
20
30
(602)
FREQUENCY
VERBAL AGGRESSION
30
20
10
0
10
20
30
(181)

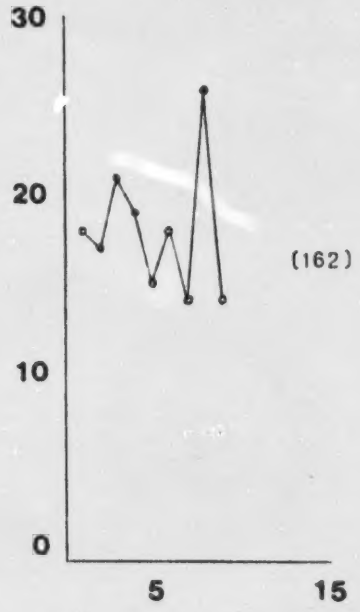
n=8

FIGURE 5

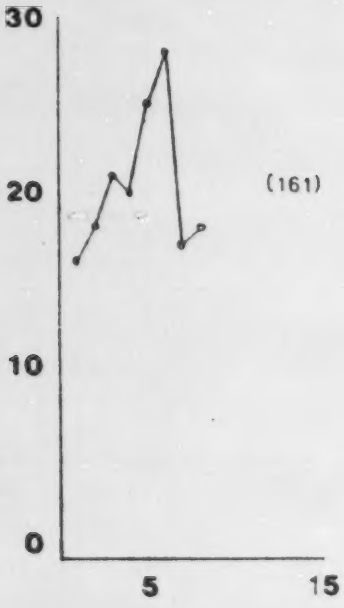
PHYSICAL AGGRESSION



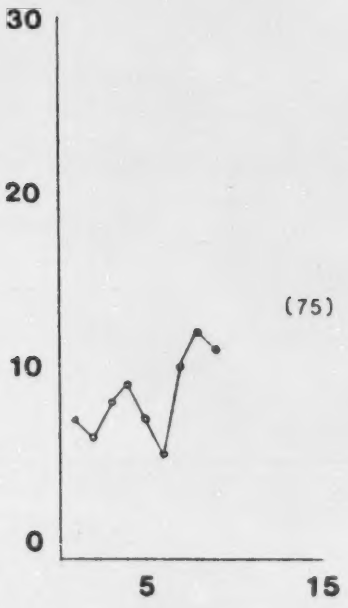
NON-COMPLIANCE



VERBAL AGGRESSION



RUNAWAY



n=8

What changes in the pattern of aggressive behavior (its topography) occurs during the course of treatment?

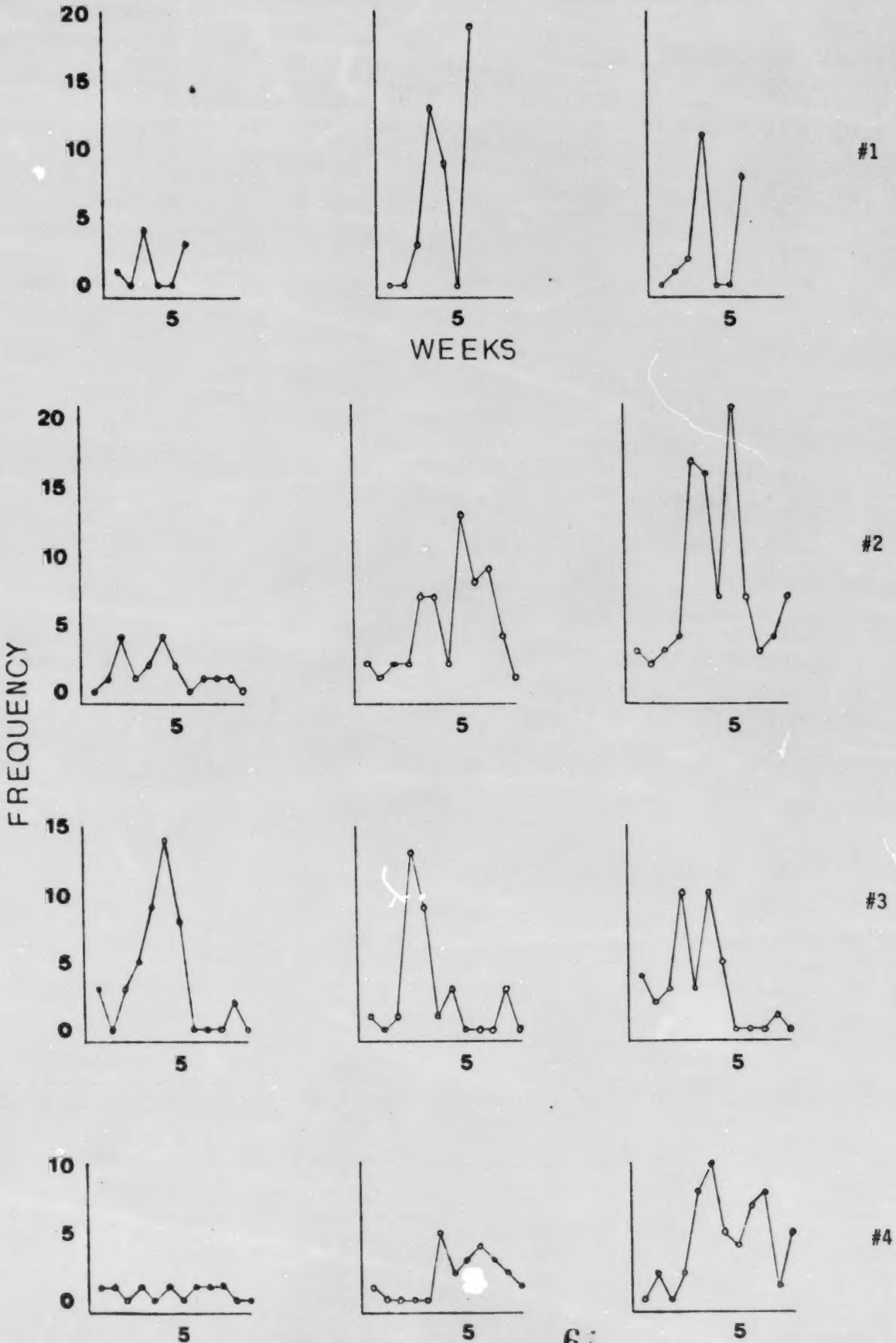
It seems that during the course of treatment this population's aggression becomes chanelled into that variant which is consequenced the least. For the most part, physical aggression is relatively easy for staff to identify, thus timeout is administered most consistently for that form of aggression. However, it is more difficult for staff to discern whether a statement consitutes verbal aggression, or is merely profane speech, jest, or a culturally-specific colloquialism. For that reason, verbal aggression is treated less consistently with timeout. That quirk seems to account for the much lower reduction of verbal aggression (versus physical aggression) noted in Figure 4. Apparently, this unwitting differential consequencing of those two aggression variants induces a shift in this population's aggression topography: the typical mix of physical to verbal aggression 1.0:3.0 (upon admission) changes to 1.0:5.3 (after about 8 weeks in treatment). We find also that once verbal aggression is reliably consequenced with timeout, non-compliance, another form of aggression that we do not treat with timeout, increases its contribution to this population's overall aggressive behavior mix. Accordingly, applicators of this treatment approach should expect these youth's aggression topography to change towards an increase in the relative frequency of those variants whose indulgence bears the least undesired consequence. Thus, it will be necessary to decide at which point aggressive derivatives are too minor to ethically justify as intrusive a reductive intervention as timeout. Notwithstanding where that line is drawn, it is imperative for an experienced professional to provide regular, hands-on monitoring to assure reasonably consistent application of this treatment model.

To what extent do these youth incite one another into aggression, non-compliance and other disruptive behavior in a residential program?

There is no question that these youth, as is true of all peer groups, instigate and reinforce one another for behaviors that they consider important. One of the most difficult, some say impossible, tasks in residential treatment is to negate these informal contingencies that militate against habilitation. The only means for doing so is close supervision, so that any dis-allowed behavior can be consistently consequenced. Concurrently, desired behavior must be reinforced. The strategy is to overwhelm the informal contingencies by making the behavior they elicit and maintain as unproductive as possible (in terms of yielding valued results). In a sense, we strive to supplant the desire for deviant behavior with the desire for socially-acceptable behavior by making the former as unattractive as possible, and rendering the latter as adavantageous as possible.

Even when that objective has been largely met, it should be expected that the aumission of a new client will lead to a general escalation of inapporpriate behavior among numerous residents. This is especially true if the new client is perceived to be physically powerful by residents. Until that youth is worked into the pecking order, some turmoil should be expected.

A related phenomenon will occur when a resident is in the midst of a chronic (2-7 day) aggressive episode. At those time, it should be anticipated that other clients will likewise become more aggressive and defiant. We are uncertain exactly how this form of social contagion occurs, but expect that the process is somewhat different for each youth. We do know thought that those youth who are emotionally disturbed are most subject to its influence. Figure 6 illustrates that point: the enraged client (#1) is introduced into the residence, and E.D. clients (#2&3) react much more vigorously than the non-E.D. client (#4).


PHYSICAL AGGRESSION
VERBAL AGGRESSION
NON-COMPLIANCE
#1
#2
#3
#4
FREQUENCY
WEEKS
20
15
10
5
0
5

Another question which is aksed frequently is how long is the average stay in time out? This varies extensively and depends upon how agitated the youth has become--which is another reason to use time out as early as possible, in the verbal aggression stage. For the typical client, stay in time out tends to be about 15 minutes, but it ranges from 10 to 140 minutes. Usually, the longest stays for them are noted during the first 2 months in treatment. For the emotionally disturbed sub-group, stay in time out averages about 40 minutes, with a range of 10 to 235 minutes. With them, stay in time out does not seem to be as related to how long they have been in treatment.

How effectively does this treatment approach prevent runaways?

Since we have had a secure setting, there have been a total of 7 runaways from those areas. These have been due primarily to staff inexperience in operating a secure unit. There have been 3 youth who had progressed to the open group home that have run away from that residence (of 14) (there have been a total of 6 incidents, involving 3 youth). That figure stands in marked contrast to the 48 runaways per month averaged by the 8 youth we treated in the open group home. Over the past 2 years, from all setting, and under various circumstances, there have been 15 runaways, involving 8 youth.

What change seems to occur in these youth during this treatment that motivates them to decrease their aggressive and runaway behavior?

Our observation indicates that most youth tend to develop strong positive relationships with staff. Technically speaking, staff becomes a potent secondary and generalized reinforcer. By treating clients consistently, humanely, and fairly, clients, many for the first time, learn what to expect of an adult and what will and will not be tolerated. This predictability seems to be reinforcing, in and of itself. Staff also provide clients with extensive praise or social reinforce-

ment, which virtually all these clients crave--they thrive on staff attention (which they'll get somehow, so it might as well be for appropriate/desired behavior). Staff also dispense reinforcers which clients earn (cigarettes, extra snacks, special clothing, etc.), and thus become associated with the reinforcing power of these. Similarily, staff assist clients in various activities which demonstrates that they are capable, powerful--this population respects power, as you will note by the differential attention provided to higher level staff (who are known to the clients). Finally, staff dispenses points constantly during the day, which again associates them with reinforcers. Cumulatively, these forces establish staff as very important persons in clients' lives--persons who direction they are likely to accept, and persons who they genuinely like.

XII. SUMMARY OF NEEDED HABILITATION SERVICES

Now that we've considered at length the goals, objectives, location, and general mechanics of treating this population, let's overview all the intervention components needed to generate a program that can accomodate any MR adolescent offenders, regardless of the severity of their behavior.

A. Point-based Token Economy. This system conveniently structures a consistent, therapeutic staff-client interaction around undesired and desired behaviors. This consistency is the hallmark of rapid behavior change. Clients behavior shifts in accord with how staff responds to it: those behaviors that bring desired staff responses will persevere and increase-- those which bring staff wrath will decrease or be eliminated. The more consistently staff is able to provide these differential consequences,the more rapidly will client behavior change in accord. The token economy, if applied faithfully, programs staff to react therapeutically to the most crucial client behaviors. Without such a structured system, staff response to client behavior will be erratic, often counterproductive, and little positive behavior change will occur. Whenever second-order treatment is utilized, where someone other than the designer is the implementor, a parrallel "treatment" or program must be designed for staff to assure its reliable application. The token economy is a vital part of staff's program. In addition, staff must receive proper training, fairly detailed work schedules, specific (written) lesson plans or training curricula, frequent and differential feedback on good and poor performance, and systematic, hands-on supervision.

B. Timeout Procedures. A token economy must be backed up by a highly aversive consequence for it to affect client behavior. Richard Foxx calls it the "doomsday" consequence. For virtually all members of this population, timeout has been determined to be a viable doomsday contingency. Without it, these youth will soon realize that staff can only admonish them for aggression, even if that aggression is physical, and directed at staff. Without question, admonitions will not dissuade this population from aggression for long. A program that admits aggressive youth and attempts to control that behavior solely with verbal prompts will quickly dissolve into anarchy: client cliques will actually be in control. Implementing timeout, especially with strong, enraged youth should be attempted only after thorough training. It is therefore necessary that the program incorporate step-by-step procedures for placing recalcitrant clients into timeout, and train its staff carefully in that process.

C. Behavior Therapy for Unusual Problems. It should be expected that some youth will present with behavior problems that require additional applications. For example, we have noted that inappropriate touching of others, especially female staff, is problematic with some clients. When such inappropriate behaviors cannot be quickly extinguished with verbal prompts, an intervention must be devised. It is therefore axiomatic that the program have the services of a trained behavior analyst. Preferably, such a person should be on-staff.

D. Psychiatric Consultation/Psychotropic Medication. Any program that accepts all referrals will receive emotionally distrubed youth who will experience recurrent serious episodes of agitation and aggression.

During these incidents, that client's safety, as well as that of other residents and staff is jeopardized. During the acute phase of their illness, repeated physical restraint, and involuntary placement into timeout is required. Psychotropic medication can reduce or even eliminate these violent episodes, and thus reduce the prospect of injury to everyone at the residence. By maintaining medication at minimal effective levels, these youth are able to progress well within the habilitation program. Gradual reductions of those level must be instituted when behavior has stabilized to determine if medication can be withdrawn, or whether a maintenance dosage is needed. Responsible use of psychotropic medication seems to be a much more humane intervention than chronic physical retraint. But to use this adjunct responsibly, the program will require the services of a psychiatrist experienced in treating emotionally disturbed retarded populations, preferably youth.

E. Group/Individual Counseling. A formal mechanism must be available for clients that have special concerns or problems. Paraprofessional treatment staff do not have the requisite skills for counseling (in most cases). At least on a consultant basis, a trained, experienced professional should conduct individual counseling, especially with the emotionally disturbed clients. Group counseling sessions should also be regularily scheduled, and invovle all clients. Possibly, a trained paraprofessional can lead groups. These should focus on common problems, concerns, and issues. Groups also provide an excellent forum for learning and practicing appropriate interpersonal skills.

F. Social Skills Training. Complex social skills are not well suited for formal learning by the mentally retarded, in terms of the step-by-step

behavioral objectives used to train various living skills. Perhaps for that reason their teaching is largely ignored in most programs for this overall population. Seemingly, in most programs staff consider that their modeling of "good" or socially appropriate behavior will somehow induce client to imitate those performances. But this notion presupposes that staff's behavior is unerringly "good", that clients can gleen from it the salient principles needed for its re-use in other contexts, and that the mentally retarded are anxious to try new behaviors. Unfortunately, none of these assumptions tend to be true. It is therefore necessary to teach these youth social skills as systematically as we endeavor to eliminate their aggression. No suitable commercial social skills training (SST) package is presently available. A good start would be to adapt the ASSET Social Skills Training Program for Adolescents (Hazel et al., 1981). This is a video-based format. Our tentative experience in SST with this population indicates that video techniques are an indispensible adjunct. Not only should the teaching vinettes be pre-recorded, but clients' role plays should be filmed so that critiques can be concretized.

G. Living Skills Training. This component is probably the most familiar to those who work with the mentally retarded. There are many commercial curricula from which to adapt a training program. One that should be examined is McGraw Hill's Skills for Independent Living, which was preparded for moderate and mild populations. It teaches nine domains widely accepted as central to community adjustment: purchasing habits, budgeting, banking, job related behavior, job search skills, home management, health care, hygiene and grooming, and interpreting functional

To their list I would add: use of community resources, use of public transportaion, drug/alcohol education, and sex education.

H. Academic Education. This is a fairly straight-forward topic. Emphasis should be on functional reading, writing, and spelling that one recurrently encounters in basic modern life. The local school district's special education consultant should be most willing to assist in the design of an on-site program (since it will keep these difficult children away from school). The district may even be maneuvered into furnishing a qualified teacher for the program.

I. Vocational Orientation. There should be some provision for providing these youth an introduction to work. An off-site, realisitic vocational setting seems most useful for this training purpose. Research indicates that a major difficulty which excludes mentally retarded persons from employment is poor work habits and poor job-related interpersonal skills. A major function of this training component must be to orient these youth to the demands of the work setting. Emphasis should be on teaching competencies such as attention to task, perseverence, timilness, and appropriate interactions with fellow workers and supervisors. Space and tools should be available for clients to work on small projects to learn tool usage. Older clients should be provided with regular maintenance duties, for which they are paid. Only clients whose behavior is no longer punctuated with aggression should participate in off-site vocational activities.

J. Recreation. The mentally retarded, in general, make non-constructive use of their leisure time. Accordingly, they tend to be bored more frequently, This boredom lends them easy victims to alcohol abuse and

to the suggestion of antisocial acts. Misusing leisure time in this manner precludes many members of this population from gaining self-esteem through leisure time or recreational accomplishments. To really habilitate the mentally retarded implicates that we also teach them how to use their non-working time to enhance themselves. For adolescents, this would include the learning of and participation in basic athletic activities, such as baseball, football, basketball, and ping pong. It would also include learning table games, such as checkers, and simple card games. They should also be taught solitary activities, such as drawing, simple woodworking, model building, and very basic repairs. To assure that youth in the program can engage in physical recreation, the residence should be planned and located to facilitate this important objective.

K. Engineered Environments. We have already discussed at lenght the supportive value of this adjunct. Suffice it to say that programs which intend on accepting any MR adolescent offender must have a secure environment in which to initiate treatment.

L. Family Involvement. This component is probably one of the most difficult to actualize, but perhaps one of the most crucial, especially in terms of how well these youths' changed behavior perseveres upon discharge. Pathological conditions within the family can quickly reverse the therapeutic gains made in treatment. Unfortunately, many families are not amenable to help if obtaining it involves the expediture of much effort, and especially resources, on their part. But those are the realities of working with offender populations. The following should be attempted by the program's social worker (it cannot be overemphasized

that the program have an on-staff social worker):

1. Regular telephone contacts (initiated by the social worker) to convey the child's progress/problems, and to answer questions that the family might have regarding aspects of the treatment program.
2. Regular client-initiated contact with the parent by telephone so progress and problems can be reported personally, and the parent-child relationship is maintained. (In some cases, the parents are a counter-therapeutic influence, and such calls cannot be permitted. Clients should purchase the privilege of calling home.)
3. Parent visits to the group home should be encouraged so they can verify that their child is "all right" and not being abused (as many youth will chronically claim), and to observe that staff is caring, attentive, and competent.
4. Social worker visits to parents' home should be schedulued regularily, distance permitting, to establish and improve a working relationship, and to provide basic guidance and advice in "familiar" territory.
5. Linkage of parents with indicated social support and mental health services is essential to help alleviate pathological conditions existing in the family.
6. And, on a very limited basis, and if the family cannot obtain that service in the community, family therapy should be provided. Crisis intervention should also be available.

XIII CONCLUSION

I think now you all understand why we contend that residential programs for this offender population cannot logically be charged to totally habilitate them. It simply does not have the resources to do so. Even if it did, given how much these youth and their families must learn, placement at such a facility would likely be for many years. But legitimately, both from a clients' right and non-duplication of services standpoint, residential programs should merely serve as the first rung in habilitating client populations whose behavior problems preclude starting higher up the ladder.

All the residential program should be asked to do is to train or prepare its clients for successful participation in the community's regular educational/support system. MR adolescent offenders have been excluded from that network because of their irresponsible behavior at its sites and in the community in general. The program's goal must therefore be to remediate these youth's behavior to where responsible participation at traditional educational sites and in the local community is feasible. As soon as that goal has been reasonably met, these youth should proceed to a more conventional living environment, and continue their habilitation within the community. In view of the just concern for client rights, and the reality of scarce resources, there is no other rational solution to the MR adolescent offender dilemma.

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XV APPENDECES

Included in this section are copies of two behavior therapy programs for MR adolescent offenders. Both are group programs, in that each client at the residence is administered the same contingencies. In the first program entitled, REDUCTION OF ANTISOCIAL BEHAVIOR, individualization comes in the form of specific problems in Section II. Individual Contingencies. Examples of what those may be are provided on pages 75 and 76. In the second program entitled, GENERALIZATION OF ADAPTIVE BEHAVIOR, individualization is provided throughout, and especially through contingency contracts (page 81).

The REDUCTION program is implemented only in a secure setting. And the GENERALIZATION program is utilized only in an open or conventional group home setting. The primary purposed of the written programs is to document the type of treatment each client is receiving. It is not intended to instruct staff how to intervene with the client. In-depth instruction on procedures are provided for that purpose.

SPECIFIC PROGRAM OBJECTIVE

REDUCTION OF ANTISOCIAL BEHAVIOR

Client: Case Number:

Program Unit: Adolescent Residential Services/

Program Monitor:

I. GROUP CONTINGENCIES

A. Target Behaviors

1. Physical Aggression - attempting or inflicting physical harm upon another person by hitting, kicking, scratching, slapping, biting, pulling hair, choking, shoving, grabbing, etc.
2. Property Destruction - intentionally breaking or damaging articles of value to self or others, or attempting to do so.
3. Verbal Abuse - taunting or intimidating others through name-calling, cursing, or threatening.
4. Uncooperativeness - refusing to follow instructions after having received two (2) consecutive verbal requests or prompts.
5. Lying - making a false statement to avoid a consequence or to gain an item or privilege.
6. Stealing - taking an item which is not owned without the voluntary permission of the owner.
7. Unauthorized Departure - leaving or attempting to leave the residence without staff permission.

B. Behavioral Objectives

1. To decrease the frequency of the following to zero: physical aggression, property destruction, and unauthorized departure. Measured in terms of no fines for these target behaviors for two (2) consecutive months.
2. To decrease the frequency of the following to a level where participation in conventional community training/education programs is feasible: verbal abuse, uncooperativeness, lying, and stealing. Measured in terms of weekly Social Point Fines of less than 40 for two (2) consecutive weeks.

C. Baseline Measure

1. Court-commitment into this residential program is accepted as an operational indicator that the client's antisocial behavior requires reduction. Antisocial behaviors common to this population have been targeted for all clients at this Unit.

2. Additional maladaptive behaviors identified during the client's initial 30-day (baseline) period on the Unit will be addressed in Section II. INDIVIDUAL CONTINGENCIES.

D. Procedures

1. Token Economy. Clients can earn two types of points (reinforcers) for desired behavior: Social Points and Training Points. Both types of Points can be used to purchase various items and privileges. And, Social Points must be forfeited when one of the antisocial target behaviors is emitted. Each client carries a Point Card between 6 A.M. and 10 P.M. (6 A.M. to 12 P.M., Friday and Saturday). All point transactions are recorded on the client's Card. Staff procedures for awarding, exchanging and fining points are outlined in the Behavior Therapy Manual.

   a. Differential Reinforcement of Other Behaviors (DRO). At the end of each hour, clients who have not performed any of the antisocial target behaviors will be awarded one (1) Social Point. Point earnings are possible from 6 A.M. to 10 P.M., and until 12 P.M. on Friday and Saturday. Thus, a maximum of 116 Social Points can be earned each week.

   b. Response Cost. Clients who demonstrate any of the antisocial target behaviors will incur a Social Point loss or fine in the following amounts:

Social Point Fine Schedule

Physical Aggression	
Towards Staff	30
Towards Client	15
Property Destruction	
Point Card/Form	5
Dish/Glass/Etc.	10
Window/Wall/Door	30
Small Appliance	50
Other	Contracted
Verbal Abuse	
Of Staff	10
Of Client	5
Uncooperativeness	
(After Two Prompts)	10
Lying	10
Stealing	20
Unauthorized Departure	
Attempted	20
Returned Self	30
Returned By Staff	40
Returned By Police	50

Only the Program Director can change the established Fine Schedule. Clients will not be permitted to aviod a Social Point Fine under any circumstances. Client complaints regarding the unfairness of a Fine will be ignored. If this protestation escalates into verbal abuse or physical aggression, Time Out will be initiated.

c. Positive Reinforcement. Clients will be rewarded with Training Points for performing targeted self-care, maintenance, and participation behaviors. The following behaviors will be reinforced with the amounts indicated:

Training Point Earning Schedule

Morning	Noon	Evening
Washing Hands/Face	Being At Meal On Time	Bathing/Showering
Brushing Teeth	Eating Appropriately	Washing Hair
Wearing Clean Clothes	Assisting With After-Meal Cleanup	Being At Meal On Time
Making Bed		Eating Appropriately
Being At Meal On Time		Assisting With Meal Cleanup
Eating Appropriately		
Assisting With After-Meal Cleanup		

Partitiicipated . . 5
On Time 5
Neat/Correct . . . 5

Maximum Earnings Per Activity 15

Attending Training And Other Scheduled Activities (client meetings, hygiene/health/first aid classes, drug education, sex education, independent living skills training, structured recreation, etc.)

Participation 5
Arrived On Time 5
Worked On All Tasks . . 5
Worked On Extra Tasks . 5
Improved Performance . . 5

Maximum Earnings Per Activity. 25

Only the Program Director can change the established Earning Schedule. Training Points will be awarded by the staff member who conducts the training/activity, or who supervises the performance of self-care/maintenance tasks.

2. Time Out. In addition to incurring a Social Point Fine, Time Out will be imposed as a consequence for certain target behaviors. Two forms will be used: Bedroom Time Out and Isolative Time Out (in the Time Out Room).

   a. Isolative Time Out. Unless otherwise specified in the Individual Contingencies section, physical aggressiona or property destruction will result in immediate placement in the Time Out Room. A client who has demonstrated during the 30-day baseline period that his verbal abuse typically escalates into physical aggression will also incur Isolative Time Out for abusive behavior. In this latter case, that client's Point Card will have been marked "VA" by the Program Director. Under no circumstances will staff allow clients to avoid Time Out. In emergency situations, the Shift Supervisor can decide that Time Out will not be implemented. The reasons for doing so must be presented in writing to the Program Director by the end of that shift.

   Clients will be placed into Time Out with minimal force. A maximum of two (2) Verbal Prompts or requests will be given. If these are ineffective, Physical Guidance is initiated for up to two (2) minutes. When that procedure fails, Physical Restraint and Transportation to the Time Out Room will be implemented.

   To gain release from Time Out, the client must refrain from screaming, kicking, flailing, or other signs of agitation for ten (10) minutes. If the client is still agitated during the last minute of this period, he will remain in Time Out for one (1) extra minute (known as a "1-minute change-over delay"). If he is not agiated during the last minute of this additional period, the client is released. Otherwise, another one (1) minute must be spent in the Time Out Room. At the end of one (1) hour, the client will be given an opportunity to leave the Room. But, if aggressive behavior is demonstrated upon release, the entire process begins anew.

   Clients who are in the Time Our Room during a scheduled meal, will be offered the opportunity to eat at the end of that meal period, and in a supervised area of the building. If no aggressive behavior is evident after eating, Time Out will be discontinued.

   Each Isolative Time Out will be recorded on a Restraint Checklist and in the client Progress Notes by the Shift Supervisor.

   Procedures for implementing Time Out using verbal prompting, Physical Guidance, and Restraint/Transport are described in the Behavior Therapy Manual.

   b. Bedroom Time Out. The anti-social target behavior, verbal abuse, will be treated by sending clients to their bedroom for Time Out. Upon observing verbal abuse, staff will give up to two (2) verbal prompts. If these are unsuccessful, physical guidance will be used for two (2) minutes to move the client into

room.

Time Out duration will be one (1) minute , with a change-over delay of one (1) minute. The same one (1) hour maximum time limit will be observed. The bedroom door will not be locked, but the client will be monitored.

If physical guidance fails to induce the client into his room, the Isolative Time Out procedure will be initiated. Also, if the client becomes aggressive or destructive during Bedroom Time Out, he will be placed into Isolative Time Out.

Each Bedroom Time Out will be recorded on the client Point Card and the Progress Notes.

3. Restriction. Clients who incur a negative Social Point balance will be restricted to the secure or closed area of the building. Exit from that area must be purchased with 75 Social Points, unless otherwise stipulated in the Individual Contingency section. The negative point balance must be re-earned before exit can be purchased.

   Clients who attempt or succeed in unauthorized departure will be placed in the closed area. Their exit price will be set by the Interdisciplinary Team.

4. Privileges. Except for items and privileges guaranteed as clients' rights, other desired items or reinforcers must be purchased with earned points. In general, Training Points will purchase items and activites available on-site. Social Points will purchase the more desirable items and activities which can be obtained only off-site. This design prevents clients from manipulating the Token Economy: they can only obtain highly desired reinforcers through significant improvements in social behavior.

Training Point Menu

Appointment with Professional Staff	30
Using Table Game (30 minutes)	30
Playing Pool (30 minutes)	60
Watching T.V./Listening to Stereo (after 5 P.M., per hour)	60
Candy Bar/Fruit/Extra Snack	75
Cigarette	75
Poster	100
Making Personal Phone Call	100
Time Off from Programming (Evenings Only, per hour)	150

SPECIFIC PROGRAM OBJECTIVE

REDUCTION OF ANTISOCIAL BEHAVIOR
Page 6

Training Point Menu (Cont'd)

*Staying Up Late (per hour) (One hour maximum, Sunday-Thursday) (Two hour maximum, Friday/Saturday)	200
Changing Room Assignments	200
Contract Items	Variable

*Not available if a negative Social Point balance exists

Social Point Menu*

Van Ride	10
Trip to Park/Boy's Club/ Recreation Center/Filed Trip/ Gym	20
Movie	40
Sports or Entertainment Event	50
Weekend Home Visit	100
Contracted Activity	Variable

*Not avialable when on restriction

All purchases will be recorded on the client's Point Card. Contracts for special items must be approved by the Program Director prior to implementation. Both procedures are outlined in the Behavior Therapy Manual.

SPECIFIC PROGRAM OBJECTIVE

REDUCTION OF ANTISOCIAL BEHAVIOR
Page 7

II. INDIVIDUAL CONTINGENCIES

A. Target Behaviors

During the 30-day baseline period, in addition to the anit-social behaviors listed in Section I, headbanging was observed almost every time was placed in Isolative Time Out. Therefore, the following is added to his list of target behaviors:

8. Head-banging - intentionally striking the head against a hard surface with sufficient force to induce physical injury.

B. Behavioral Objectives

In addition to the behavioral objective listed in Section I, the following will be added to 's program:

3. To decrease the frequency of head-banging behavior to zero. Measured in terms of recorded incidents for two (2) consecutive months.

C. Baseline Measure

Baseline observations indicate that Mark engages in head-banging only when he is placed into Isolative Time Out. Almost each instance of Isolative Time Out has triggered this type of self-abuse. These data establish that requires an alternative secured time out procedure.

D. Additional/Alternative Procedures

Guided Relaxation will be used to treat those behaviors targeted for mandatory Isolative Time Out in Section I. These are:

1. Physical aggression,
2. Property destruction, and
3. Verbal abuse (if Bedroom Time Out has not succeeded).

Procedures for implementing Guided Relaxation are outlined in the Behavior Therapy Manual.

SPECIFIC PROGRAM OBJECTIVE

REDUCTION OF ANTISOCIAL BEHAVIOR
Page 7

II. INDIVIDUAL CONTINGENCIES

A. Target Behaviors

During the 30-day baseline period, no antisocial behavior in addition to those identified in Section I were observed at a frequency which requires reductive intervention.

B. Behavioral Objectives

No additional behavioral objectives are necessary at this time.

C. Baseline Measure

Baseline data indicate that 's property destruction has not been decreased significantly with the application of Isolative Time Out. It has also been observed that he intensely dislikes cleaning his room and common areas. Together, these factors suggest that Restitutional Overcorrection may be effective in decreasing 's destructive episodes.

D. Additional/Alternative Procedures

Restitutional Overcorrection will be used as an adjunct to treat 's destructive behavior. Upon release from Isolative Time Out, he will be required to clean/straighten and repair (when possible) the damaged area. In addition, will be required to:

1. Wipe down all furniture in the room,
2. Arrange all furniture orderly, and
3. Vaccum the floor.

If the incident occurs in his bedroom, will perform these tasks in all five (5) bedrooms. If it occurs in the training area, he will perform them in all four (4) training rooms.

Step-by-step procedures for implementing Restitutional Overcorrection are outlined in the Behavior Therapy Manual.

SPECIFIC PROGRAM OBJECTIVE

REDUCTION OF ANTISOCIAL BEHAVIOR
Page 8

E. Client Rights and Consent

1. This program has been reviewed by the Program Director and the Human Rights Committe to insure that no client rights will be violated.

2. Written informed consent in accord with TDMHMR Rules of the Commissioner (302.04.07.003 [7, A-D], 302.07.009 [a, A-C][c]) will be obtained from the guardian/parent and attached to this program. If written consent cannot be obtained, an independent consultant will be contacted to evaluate the client and provide support for use of this program.

F. Program Direction and Monitoring

1. This program will be operated and monitored under the direction of the Unit Psychologist, who has been approved by the Behavior Therapy Committee as the Program Director.

2. The procedures which comprise this program will be implemented by technical and professional staff assigned to the Unit. All staff who apply this treatment program will have been trained in at least:

   a. Basic Operant Conditioning Principles
   b. Token Economy Implementation
   c. Verbal Prompting, Physical Guidance, Restraint, and Transporting Reluctant Clients
   d. Time Out Rational and Implementation
   e. All Procedures cited in the Individual Contingencies sections

G. Data Collection

1. Frequency data will be collected all behavior targeted in both sections of this Program Objective, and will be graphed weekly.

2. Social Point earnings and losses and Time Out episodes will be tallied and graphed weekly.

H. Revision

1. Need for revision of this program will be indicated if the client does not progress towards the behavioral objectives within one (1) month of implementation. Modification of this program will take place in the Individual Contingencies section.

2. Program revisions will be made if medical factors emerge which contradict any procedures specified herein. Such changes will be made in the Individual Contingencies section.

_____ _____

, Program Director Date

GCD:sf

SPECIFIC PROGRAM OBJECTIVE

GENERALIZATION OF ADAPTIVE BEHAVIOR

Client: Case Number:

Program Unit: Adolescent Residential Services/

Program Monitor:

A. Target Behaviors

1. The following behaviors and/or behavior classes have are targeted for maintenance and/or increase. Behavioral definitions and evaluative criteria for each are specified in the Behavior Therapy Manual.

   a. Out of bed on time
   b. Bedmaking
   c. Personal room cleaning
   d. Personal hygiene
   e. Meal preparation/clean-up assistance
   f. Table manners
   g. Residence clean-up assistance
   h. In bed on time
   i. Helping others
   j. Working out conflicts
   k. Avoiding confrontations
   l. Appropriate social behavior on van
   m. Appropriate social behavior during activities/outings
   n. Participation in specified training sessions
   o. Other (to be determined by Program Director)

2. The following behaviors and/or behavior classes are targeted for maintenance at their present level or decrease (indicated by X). Behavioral definitions for each are specified in the Behavior Therapy Manual.

   Physical Aggression
   Verbal Abuse
   Property Destruction
   Stealing
   Unauthorized Departure
   Illegal Substance Use
   Public Disturbance
   Invasion of Another's Privacy
   Inappropriate Sexual Behavior
   Other (to be determined by Program Director)

B. Behavioral Objectives

1. To maintain or increase the frequency of the adaptive behaviors listed in A.1. Target Behaviors at or above baseline levels for eight (8) consecutive weeks. Measured in terms of possible points earned per week.

2. To maintain or decrease the frequency of maladaptive behaviors listed in A.2. Target Behaviors at or below baseline levels for eight (8) consecutive weeks. Measured in terms of total fines for maladaptive behaviors incurred per week.

C. Baseline Measure

1. Baseline measures will be obtained from _____ to _____. During this period, _____ will not carry his own Point Card. Instead, staff record each incidence of targeted adaptive and maladaptive behavior at a centrally-located data sheet. During this period, all reinforcers available on the unit can be recived without being contingent upon behavior. Staff recording procedures are outlined in the Behavior Therapy Manual.

2. Information on antecedent and consequent behaviors during the baseline period is not included in this program since it would not be helpful in its implementation.

D. Procedures

1. Token Economy. This program is designed to maintain the decreases in antisocial behavior which was attained at _____ House, and to facilitate the generalization of prosocial behavior learned there. After the baseline period, each client will carry a personal Point Card between 6 A.M. and 10 P.M. (6 A.M. to 12 P.M., Friday and Saturday). Next to each behavior targeted for maintenance/increase or decrease, the points earned or lost by performance of that behavior will be listed. Point values for all behaviors may vary between clients, and will be adjusted by the Program Director as indicated by the data.

   a. Awarding and Fining Points. Whenever the client performs a behavior targeted for maintenance or increase, staff will reinforce its occurence by punching a hole next to it on the Point Card (with hole punch issued at the beginning of each shift). Targeted antisocial behaviors will be fined in the same manner. Point earnings will be calculated daily (by the 11 P.M. - 7 A.M. shift supervisor). Net point totals will also be computed and graphed on a large "feedback" chart for certain clients. Staff procedures for awarding and fining points are outlined in the Behavior Therapy Manual.

   b. Point Exchange. Points will be exchanged on a weekly basis, but not for specific backup reinforcers. Instead, the behaviors of the previous week will determine which items, activities, or

SPECIFIC PROGRAM OBJECTIVE

GENERALIZATION OF ADAPTIVE BEHAVIOR
Page 3

privileges can be obtained during the present access
all available reinforcers, the client must att oint
Total which was specifically set for him. The 1
will be stated as a percentage: total weekly point
minus number of points fined, divided by total number nt
earnings possible. The Program Director will determine or
more Percentage Goal(s) for each client, the highest of which
must be reached to access all available backup reinforcers.
At lower Percentage Goals, one or more backup reinforcers must
be forfeited. The following Percentage Goals and privilege loss
consequences will apply to _____:

Percentage Goals	Privileges Forfeited
_____	None
_____	_____
	_____
	_____
_____	All listed above, and
	_____
	_____
	_____
	_____
_____	All listed above, and
	_____
	_____
	_____
	_____
	_____
	_____

The Program Director will adjust Percentage Goals and vary Privileges Forfeited as indicated by the data.

c. Restriction. Some antisocial behaviors will be considered sufficiently serious to warrant an immediate loss of privilege in addition to a point fine. The following antisocial behavior(s) will be targeted for loss of the privilege indicated each time _____ enages in it/them:

Behavior	Privilege Forfeited
Physical Aggression	_____
Verbal Abuse	_____
Property Destruction	_____

Behavior	
Stealing	_____
Unauthorized Departure	_____
Illegal Substance Use	_____
Public Disturbance	_____
Invasion of Another's Privacy	_____
Inappropriate Sexual Behavior	_____
_____	_____
_____	_____

The Program Director will add and/or remove behaviors from this list and vary the privileges to be forfeited by each, as indicated by the data.

2. Self-Evaluation. Whenever a client has performed a behavior targeted for maintenance or increase successfully for two (2) consecutive weeks, he may be asked to begin evaluating the quality of its performance. Behaviors to be self-evaluated will be determined by the Program Director and indicated on the client's Point Card. Evaluative criteria and staff procedures for initiating Self-Evaluation are described in the Behavior Therapy Manual.

3. Credit Economy. Once a client has evaluated his/her performance of a behavior targeted for maintenance/increase successfully for two (2) consecutive weeks, the Program Director can "credit" that behavior. In this process, a Credit Contract is negotiated with the client which specifies that he/she will receive credit for the behavior each day. All behaviors maintained on credit will be identified on the client's Point Card. Random sampling will be used to monitor the continued occurrence of all credit behaviors. At the Program Director's discretion, a client may be placed on a complete credit system, and no longer required to carry a Point Card. Decreases in the qualitative/quantitative performance of behaviors targeted for maintenance and increase, and/or an increase in antisocial behaviors will result in partial or complete re-implementation of the point-based token economy. Staff procedures for utilizing the Credit Economy are outlined in the Behavior Therapy Manual.

4. Contingency Contracts. In addition to the Credit Contract used to implement the Credit Economy, special behavioral contracts will be negotiated with clients who have needs that are not adequately addressed by the other components of this program. All Contingency Contracts will be developed by the Program Director.

E. Client Rights and Consent

1. This program has been reviewed by the Program Director and the Human Rights Committee to insure that no client rights will be violated.

2. Written consent in accord with TDMHMR Rules of the Commissioner (302.04.07.003 [7, A-D], 302.07.009 [a, A-C][c]) will be obtained from the guardian/parent and attached to this program. If written consent cannot be obtained, an independent consultant will be contacted to evaluate the client and provide support for use of this program.

F. Program Direction and Monitoring

1. This program will be operated and monitored under the direction of the Unit Psychologist, who has been approved by the Behavior Therapy Committee as the Program Director.

2. The procedures which comprise this program will be implemented by technical and professional staff assigned to this Unit. All staff who implement this treatment program will have been trained in at least:

   a. Basic Operant Conditioning Principles
   b. Token Economy Implementation
   c. Credit Economy Implementation
   d. Any New Techniques for Specific Clients

G. Data Collection

1. Frequency data will be collected on the number of fines incurred each week, and will be graphed.

2. Percentage of points earned (in comparison to total possible earnings) will be computed at one week intervals, and graphed.

H. Revision

1. Need for revision of this program will be indicated if the client does not progress towards the behavioral objectives within one (1) month of implementation. Modification of this program will be in the form of an addendum in those instances where additional procedures are indicated.

2. Program revisions will be made if medical factors emerge which contraindicate any procedures specified in this plan. Such changes will be specified in an addendum to this plan.

_____ _____

, Program Director Date

GCD:sf